

**Managing within the challenges &  
tensions facing the 21<sup>st</sup> Century UK NHS  
Managers: NHS Managers' perceptions  
of their public image & the implications  
for their self and work identity.**

**Faruk Merali**

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This thesis is dedicated to the memory of my late beloved mother, Zerah Merali. I only knew her as a child but I know she would have been proud.

# **List of Contents**

<b>Acknowledgements</b>	<b>1</b>
<b>Abstract</b>	<b>3</b>
<b>Chapter 1: Introduction</b>	
1.1 Introduction	5
1.2 Background Context & Rationale for Study	5
1.2.1 Overview of the NHS & Role of NHS Managers	5
1.2.2 Events & Developments leading the Author to embark on this Study	8
1.3 Aim & Objectives of Study	12
1.4 Structure of Thesis	13
1.5 Conclusion	14
<b>Chapter 2: The UK Healthcare Sector</b>	
2.1 Introduction	15
2.2 The UK Public Healthcare Sector & NHS Managers	15
2.2.1 The UK Public Healthcare Sector	15
2.2.1.1 An Overview of Healthcare in Pre-NHS Britain	17
2.2.1.1.1 The Birth of the NHS & a Summary of its Early Evolution: 1948-1970	17
2.2.1.1.2 A Summary of the Development of the NHS: 1970s and 1980s	18
2.2.1.1.3 A Summary of the Development of the NHS: 1990s to 2010	20
2.2.1.1.4 A Summary of the Development of the NHS under the Present Government: 2010 to Present	25
2.2.2 NHS Managers	27
2.3 The UK Private Healthcare Sector	31
2.4 Concluding Observations	34

## Chapter 3: Literature Review

3.1	Introduction	36
3.2	Organisation Culture	37
3.2.1	Introduction	37
3.2.2	Defining & Understanding Organisation Culture	39
3.2.3	Organisation Culture & Theoretical Perspectives	41
3.2.4	Defining & Understanding Organisation Subculture	43
3.2.5	Some Models & Instruments Useful For Designing, Exploring, Assessing & Changing Organisation Cultures	44
3.2.5.1	Schein's model	44
3.2.5.2	Hofstede's National Cultural Dimensions	47
3.2.5.3	Quinn's Competing Values Framework	48
3.2.5.4	Harrison's Culture Quadrant	50
3.2.6	This Study's Adopted Stance to Understanding & Exploring Organisation Culture	52
3.2.7	NHS Organisation Culture	53
3.2.8	NHS Managerial Culture	58
3.3	New Institutional Theory	66
3.3.1	Introduction	66
3.3.2	Distinguishing between "Old" & "New" Institutional Theory	67
3.3.3	New Institutional Theory: Its Relevance & Significance to this Study	68
3.3.4	NHS Managers' Views of their Public Image	71
3.4	Self & Work Identity Theory	77
3.4.1	Introduction	77
3.4.2	Understanding Individual Identity: Approaches & Theories	78
3.4.3	Theoretical Perspectives & Approaches to Understanding Individual Identity in Organisation Studies	79
3.4.3.1	Social Identity Theory	81
3.4.3.2	Psychoanalytic Approach	82
3.4.3.3	Foucauldian Perspective	83
3.4.3.4	Symbolic Interactionist Approach	85
3.4.3.5	Narrative Based Approaches	86
3.4.4	Theoretical Approaches to Exploring & Understanding Self-Identity	88
3.4.4.1	Self-Identity	88
3.4.4.2	Identity Regulation	92
3.4.4.3	Identity Work	92
3.4.4.4	Work Identity: Managerial & Professional Identity	94
3.4.5	NHS Managers' Self & Work Identity	96

3.5	Corporate Social Responsibility (CSR)	99
3.5.1	Introduction	99
3.5.2	Overview of CSR: Theoretical Viewpoints & Approaches	101
3.5.2.1	CSR: Early Origins & the Shareholder Centred Viewpoint	103
3.5.2.2	CSR: The Enlightened Organisational Self-Interest Viewpoint	104
3.5.2.3	CSR: The Stakeholder Viewpoint	105
3.5.3	CSR: Approaches & Perspectives	105
3.5.3.1	CSR Strategies & Practice: Private Sector Organisations	107
3.5.3.2	CSR Strategies & Practice: NGOs & Public Sector Organisations	110
3.5.3.3	CSR Practice: Recognition of the Commitment & Contribution of Staff within the CSR Strategies of Organisations in the Private, Public & NGO sectors	114
3.6	Concluding Remarks	118

## **Chapter 4: Methodology**

4.1	Introduction	120
4.2	Research Methodology: Considerations, Rationale & Choices	120
4.2.1	What is Knowledge? – Ontological & Epistemological Considerations	122
4.2.2	Competing Philosophies: Approaches to Understanding Truth & Knowledge in the Social Sciences	124
4.2.3	Philosophical Tradition of the Naturalists & the Interpretivists	125
4.2.4	Structuralism & Post-Structuralism	127
4.2.5	Rationale for the Methodological Position adopted in this Study	130
4.3	Research Designs & Methods	132
4.3.1	Qualitative & Quantitative Research Designs & Methods	133
4.3.2	Primary Research	142
4.3.3	Pilot Study	148
4.4	Data Analysis	149
4.4.1	Analysis of the Semi-Structured Interviews	149
4.4.2	Analysis of the Questionnaires	153

4.5	Concluding Remarks	154
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## **Chapter 5: NHS Managers & the NHS Managerial Culture**

5.1	Summary of Chapter	156
5.2	Findings	156
5.2.1	Findings: NHS Managers	157
5.2.2	Findings: Private Healthcare Managers	160
5.3	Discussion	164
5.4	Synopsis & Concluding Remarks	174

## **Chapter 6: NHS Managers & Their Perceived Public Image**

6.1	Summary of Chapter	176
6.2	Findings	176
6.2.1	Findings: NHS Managers	176
6.2.2	Findings: Private Healthcare Managers	183
6.3	Discussion	187
6.4	Synopsis & Concluding Remarks	200

## **Chapter 7: NHS Managers' Self & Work Identity**

7.1	Summary of Chapter	203
7.2	Findings	203
7.2.1	Findings: NHS Managers	203
7.2.2	Findings: Private Healthcare Managers	207
7.3	Discussion	211
7.4	Synopsis & Concluding Remarks	225

## **Chapter 8: NHS Managers & Social Responsibility**

8.1	Summary of Chapter	229
8.2	Findings	229
8.2.1	Findings: NHS Managers	229
8.2.2	Findings: Private Healthcare Managers	233
8.3	Discussion	237
8.4	Synopsis & Concluding Remarks	247

## **Chapter 9: Summary, Conclusions, Practical Implications & Scope for Further Research**

9.1	Introduction	251
9.1.1	Study Aim, Objectives, Context & Rationale	251
9.1.2	Objectives of the Study	253
9.2	Summary: Theoretical Contribution	254
9.2.1.1	Objective 1	254
9.2.1.2	Objective 2	258
9.2.1.3	Objective 3	261
9.2.1.4	Objective 4	265
9.3	Key Conclusions & their Practical Implications	271
9.4	Contribution to Knowledge	274
9.5	Significance of this Study	276
9.6	Limitations of the Study	278
9.7	Avenues for Further Research	279
9.8	Final Remarks	280

<b>References</b>	282
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## **Appendices:**

Appendix A: Schedule of Interview Questions

Appendix B: Research Questionnaire

Appendix C: Examples of Coding used for Interview Transcripts

Appendix D: Demographic & Professional Profile of Interviewees



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# **Managing within the challenges & tensions facing the 21<sup>st</sup> century UK NHS managers: NHS managers' perceptions of their public image & the implications for their self and work identity.**

## **Abstract**

The UK NHS which is the largest organisation in Europe provides high quality healthcare free at the point of delivery to all its citizens. NHS managers play an instrumental role within it as they are expected to implement the various government led reforms designed to make the NHS an increasingly efficient, effective and accountable organisation.

This study is concerned with examining the NHS managerial culture in the context of the various challenges and tensions facing the 21<sup>st</sup> century NHS managers. The study explores the NHS managers' core values with a view to investigating the relative strength of the managers' commitment towards altruistic based values befitting the NHS ethos. Furthermore given that it is widely recognised that the NHS managers believe the public hold a generally negative view of them, this study also develops an understanding of the implications of the NHS managers' negative perceived public image for their self and work identity. The importance of how managers perceive their self and work identity and how they believe they are perceived by others has implications for their work performance, organisational commitment and satisfaction.

Through a qualitative based research design the study draws upon semi-structured interviews with twenty healthcare managers working in the public and private sectors within London and explores their views, perceptions and experiences in relation to the above issues. The

interviewees consisted of healthcare managers working in an Acute Care NHS Trust and for comparative reasons also included managers who worked in a large private sector hospital. The comparative interviews were useful in determining the extent to which the key issues central to this study were unique to the NHS managerial culture or whether they were equally pertinent to the wider healthcare managerial sector. The main theoretical framework underpinning this study is derived from and is relevant to Organisation Culture, New Institutional Theory, Self and Work Identity Theory and Corporate Social Responsibility. These relatively disparate fields of study are drawn upon in an integrated manner to explore and discuss the findings as they prove useful in developing a more holistic and deeper understanding of the key issues central to this study.

The study findings demonstrate that the majority of NHS managers had actively sought the opportunity to work in a caring based profession such as the NHS because it was underpinned by altruistic based values thereby demonstrating a high level of commitment to these values. Unlike the private healthcare managers, all the NHS managers interviewed reported that they believed the public viewed them negatively and for many of the NHS managers this caused tensions in relation to their self and work identity. Half of the NHS managers, regardless of whether they came from clinical or non-clinical backgrounds, reported emotions of demoralisation, frustration, irritation and anger as a result of this negative perceived public image. These findings provide unique and hitherto unexplored insights into the challenges and tensions facing NHS managers. Possible mitigating strategies and potential policy implications are explored in this thesis.

# **Chapter 1: Introduction**

## **1.1 Introduction**

This introductory chapter begins by providing an outline of the background context and rationale for this study followed by setting out the aim and objectives of the study. The background context includes an overview of the UK National Health Service (NHS)<sup>1</sup> along with an outline of the role of NHS managers within it. It also provides an account of the events and developments that have led the author to embark on the study reported in this thesis. For ease of reference, towards the end of the chapter an outline of the structure of this thesis is provided which includes a brief overview of the main aspects covered in each of the nine chapters comprising this thesis.

## **1.2 Background Context & Rationale for Study**

Since this study is based on the NHS and the NHS managerial culture a brief overview of the NHS and the role of NHS managers will provide a useful framework for understanding the context and significance of this study.

### **1.2.1 Overview of the NHS & Role of NHS Managers**

The NHS which represents the UK public healthcare sector was incarnated in 1948 with the main principle of providing high quality healthcare free at the point of delivery to all its citizens. This year as it celebrates its 66<sup>th</sup> anniversary it has grown to become the fourth largest organisation in the

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<sup>1</sup> For ease of reference the “UK NHS” will be referred to as the “NHS” throughout this thesis.

world and the largest organisation in Europe. It employs around 1.36m workers (which including about 37,200 managers) and has an annual expenditure budget of approximately £106.6bn (NHS Confederation, 2013). The high profile given to the celebration of the role of the NHS in British society during the opening ceremony of the London 2012 Olympic Games is testimony to the extent of national pride and affection felt for the NHS. Not surprisingly given that the NHS is the largest public sector organisation in the UK it is viewed as a political hot potato and is thereby subjected to constant and significant public scrutiny. Its sheer size, high public profile and complexity of operations makes it of interest to a broad range of stakeholders which include government policy formulators, practitioners, academics and the general public at large.

Since its birth in 1948 the NHS has evolved through a plethora of complex government led reforms as it has adapted and adjusted to the changing context of the UK economic and political landscape. As it currently navigates through the second decade of the 21<sup>st</sup> century it is experiencing difficult and challenging times in seeking to survive and continue to deliver high quality free healthcare especially in the context of the current austerity drive typical of the political, economic and social landscape affecting much of present day Europe. In fact the NHS is presently experiencing yet another wave of major reforms precipitated by the Health & Social Care Act 2012 and the scale of these reforms is so unprecedented that Sir David Nicholson, the Chief Executive of the NHS, has described them as being large enough to be “seen from space” (BBC News, 2013). Whilst broad in scope the principle aims of these current reforms<sup>2</sup> are to further embed the values related to free market competition within the NHS in order to

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<sup>2</sup> A detailed outline of these reforms is provided in section 2.2.1.1.4.

increase efficiency and improve patient care whilst at the same time reduce the NHS budget expenditure by up to £20bn (Ham, 2012). Overall the future of the NHS as a result of these reforms looks to be even more challenging as more and more is expected from the NHS albeit with a reduction in available resources.

NHS managers hold the main responsibility for managing the NHS resources in order to ensure the effective and efficient delivery of high quality patient healthcare. Prior to the recommendations of the Griffiths Report<sup>3</sup> in 1983 (DHSS, 1983) the NHS was managed on a "consensus management" based approach by multi-disciplinary teams of officers from various professional groups consisting of doctors, nurses and administrators (Black, 1995). This early style of management was however deemed by the government of the day to be inefficient, bureaucratic and wasteful of the resources provided to the NHS. The Griffiths Report recommendations led to the introduction of General Managers and "line management" to replace the "consensus management" style. Managers were given the main responsibility for implementing government reforms and achieving challenging government determined targets so as to continuously develop an ever more efficient, effective and accountable organisation<sup>4</sup>. Managers therefore gained a prominent status in the NHS and managerialism became the favoured government agenda not only for the NHS but also for the wider public sector.

The future role of NHS managers is likely to get even more demanding and challenging as a result of the current NHS reforms introduced by the Health and Social Care Act 2012<sup>5</sup> which seek to reduce management costs in the

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<sup>3</sup> The background to the Griffiths Report is provided in section 2.2.1.1.2.

<sup>4</sup> A more detailed account of the role of NHS managers is provided in section 2.2.2.

<sup>5</sup> See section 2.2.1.1.4 for an outline of the reforms related to this Act.

NHS by around 50% mainly through management redundancies. These reforms aim to further cut bureaucracy within the NHS and transfer the burden of the management of the NHS to the Commissioning Board (CB) and the Clinical Commissioning Groups (CCGs). Consequently there will be an even greater demand placed on the reduced remaining numbers of managers in the NHS as they continue to play an instrumental future role within the CB and CCGS in the overall effective management and performance of the NHS (Ham, 2012). Since NHS managers will undoubtedly continue to occupy a significant role in the NHS, it is within this context that this study has aimed to critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21<sup>st</sup> century NHS managers. Whilst the section above provides a useful framework for understanding the context and significance of this study, the following section provides the background personal context in relation to the events and developments which led the author to develop research interests in this field and to embark upon this study.

### **1.2.2 Events & Developments leading the Author to embark on this Study**

This section highlights some of the key events and developments that influenced and contributed towards shaping the overall ideas and design of this study.

The journey that sowed the seeds for this study began during the author's undergraduate degree studies over fifteen years ago. At that time the analysis of a case study within a module related to Organisation Behaviour titled "Southglam: Managing Organizational Change in a District Health Authority" (Reed & Anthony, 1993) sparked the author's curiosity and



scholarly interest into issues connected to the NHS managerial culture. The case study was concerned with the changes affecting the NHS as a result of the recommendations of the Griffiths Report and the implications arising therein for the NHS managerial culture. The study of this case led to an understanding and appreciation of the significance of the role of NHS managers in relation to the various complexities and challenges they face in their quest to effectively manage the NHS. This initial scholarly interest in the role of NHS managers led the author to opt for a final year undergraduate supervised research project related to exploring issues connected to the NHS managerial culture and more specifically to understand the nature of the NHS managers' core values. The experience of undertaking this research project further fuelled the author's curiosity and interest into issues connected to this field and provided the impetus to embark on a more substantial research study which formed the basis of the author's MSc based Management Research dissertation project undertaken in 2000. That project explored the views and perceptions of the NHS managers in relation to the various government led reforms which had been implemented at the time and also investigated the impact of those reforms on the NHS managerial culture. Since then the author has continued to develop his research interests relating to a wide range of issues connected to the NHS managerial culture (Merali, 2003; 2005; 2006; 2009) and continued testimony to this on-going research interest in this field is the study reported in this thesis.

As already mentioned the ideas for the study reported in this thesis have evolved and were influenced by knowledge and insights developed through research in this area undertaken by the author prior to this study. Two previously reported studies undertaken by the author in 2005 and 2006

stand out as being particularly influential in developing the aim and objectives of this study and also helped to shape the design of the methodology adopted in this study. It would be useful at this point to briefly outline the nature of these two previous studies so as to understand how they influenced and shaped the overall ideas and design of the study reported in this thesis. The study reported in 2005 explored the extent of the NHS managers' commitment to a socially responsible role while the study reported a year later went on to explore the extent to which the development of an explicit strategy towards social responsibility in the NHS would positively influence the commitment and contribution of NHS managers. Both studies adopted a qualitative based methodology with an inductive approach which is similar in nature to the one adopted in this study. The study published in 2005 involved semi-structured interviews conducted in 2000 with twenty-eight NHS managers working in three different London based NHS Trusts whilst the study published a year later involved semi-structured interviews undertaken in 2005 with twenty NHS managers working in two of the same three NHS Trusts involved in the earlier study. Six of the managers involved in the earlier study were also re-interviewed in the second study and the longitudinal nature of these two studies provided an important opportunity for the researcher to identify additional relevant issues that emerged over the period of the two studies. For example the repeat interviews allowed an opportunity for the researcher to investigate whether there had been any changes to the perceptions and views expressed by the managers from their previous interviews and to explore any possible reasons for this. Whilst these previous studies provided interesting insights into a wide range of issues related to the NHS managerial culture, including the extent of the NHS managers' commitment towards behaving in a socially responsible manner

and their perceptions of their public image, these studies unearthed additional issues deemed worthy of further research. For example it became clear that an understanding of the implications of the NHS managers' perceived negative public image upon their self and work identities was a relatively unexplored area. The quest for this understanding provided a unique and important opportunity for the development of the aim and objectives of this study as identified in the next section.

As detailed in the chapter on methodology (chapter 4), whilst the study reported in this thesis draws on primary research involving interviews with twenty healthcare managers (half working in the NHS and the other half working in the private sector), five of the NHS managers involved in this study were also involved in the previous two studies referred to above (three of these five managers were interviewed for the second time and the remaining two managers were interviewed for the third time in this study). The repeat interviews undertaken in this study also provided a useful opportunity for the researcher to re-visit some of the issues that had emerged in the previous interviews in order to explore the extent to which there had been any changes to the managers' views or perceptions and to explore possible reasons for this. As explained in chapter 4, some of the findings emerging from this study were considered and compared with the findings from the two separate reported studies undertaken by the author previously. This provided a valuable opportunity to assess the extent of the validity and reliability of the findings reported in the two previously reported studies by the author when compared to the findings emerging from this study.

Although there were similarities in the methodology adopted in this study with those reported by the author previously there were also some key

differences. For instance whilst the previous two studies reported by the author focused on developing insights into the realities, views and perceptions of NHS managers related to the NHS managerial culture through interviews undertaken exclusively with NHS managers, the study reported in this thesis involved additional comparative interviews with ten healthcare managers working in a private hospital. The comparative interviews with the private healthcare managers were useful in determining the extent to which the key issues explored during the interviews with the NHS managers were unique to the NHS managerial culture or whether they were equally pertinent to the wider healthcare managerial sector.

Having provided the background context which influenced and shaped this study, the following section sets out the aim and objectives of this study.

### **1.3 Aim & Objectives of Study**

The aim of this study is to critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21<sup>st</sup> century NHS managers. The achievement of this aim has been supported by the following four objectives:

1. To identify and explore the NHS managers' perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner.
2. To explore the healthcare managers' views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS.
3. To explore the healthcare managers' self and work identities.

4. To critically evaluate the Corporate Social Responsibility (CSR) strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers.

Whilst each of the four objectives above were designed to facilitate the achievement of the overall study aim, these objectives were designed in an interconnected manner such that the objectives relate to each other. This allowed for a more holistic and deeper understanding of the key issues of central significance to this study. The following section outlines the structure adopted in this thesis.

#### **1.4 Structure of Thesis**

This thesis comprises nine chapters. The next chapter (chapter 2) provides the relevant background context relating to the UK healthcare sector and the role of healthcare managers working in the public and private sectors. The third chapter consists of a critical literature review of the concepts related to Organisation Culture, New Institutional Theory, Self and Work Identity Theory and Corporate Social Responsibility which make up the main theoretical framework underpinning this study. These relatively disparate fields of study are drawn upon in an integrated manner in order to explore and discuss the findings emerging from this study so as to develop a more holistic and deeper understanding of the issues central to the aim and objectives of this study. Chapter 4 is concerned with the methodology adopted in this study and begins with a discussion of the various methodological options available to the researcher including an examination of their ontological and epistemological basis. This is

followed by a detailed rationale underpinning the identification and selection of the adopted research methodology for this study. Chapters 5-8 provide an analysis and discussion of the findings associated with each of the four objectives of this study through drawing upon the relevant theoretical frameworks. The contribution of the findings in relation to developing the existing research and knowledge in the field is highlighted within each of these chapters. The final chapter (chapter 9) provides an overview and summary of the study. It outlines the key conclusions emerging from the study and considers their practical implications. In addition to outlining the contribution to knowledge made by this study, the final chapter also highlights the significance of this study, its limitations and identifies potential avenues for further research.

## **1.5 Conclusion**

This introductory chapter has provided an overview in terms of outlining the background context and rationale for the study along with setting out the aim and objectives driving the study. It has also provided an outline of the overall structure adopted in the thesis. The next chapter provides the background information relating to the UK healthcare sector.

## **Chapter 2: The UK Healthcare Sector**

### **2.1 Introduction**

As the overall aim of this study is to “critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21<sup>st</sup> century NHS managers”, this chapter provides background information relating to the UK healthcare market which consists of both the public and private healthcare sectors. Additionally given that the main focus in this study relates to exploring the NHS managerial culture, this chapter also provides background information relating to the role and functions of NHS managers.

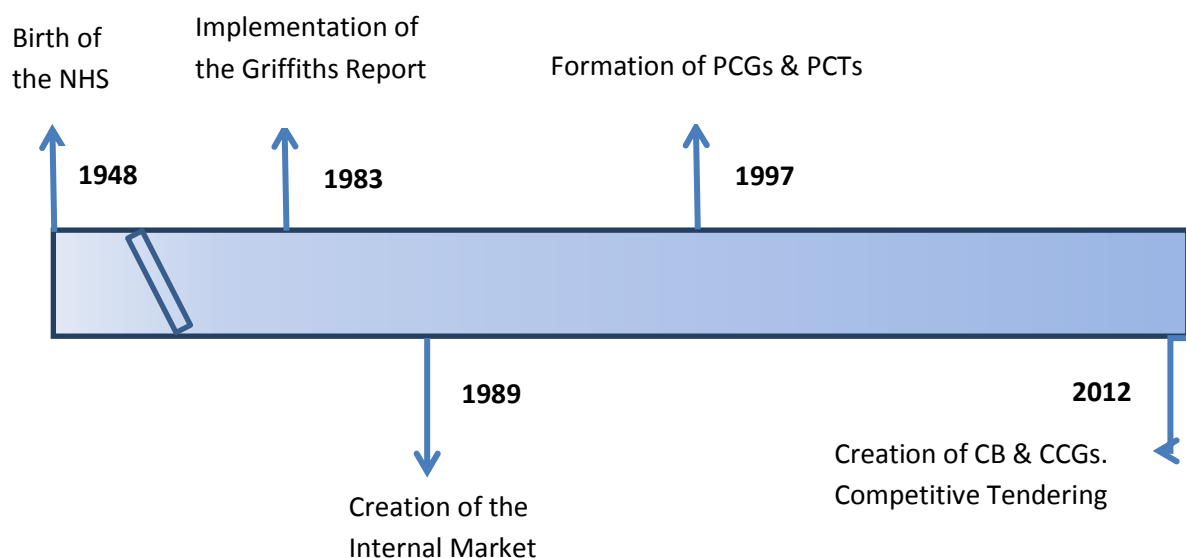
### **2.2 The UK Public Healthcare Sector & NHS Managers**

#### **2.2.1 The UK Public Healthcare Sector**

The NHS represents the UK public healthcare sector and was incarnated in 1948 with the main principle of providing free care for every man, woman and child from cradle to grave (Webster, 1992). Today the NHS is the largest organisation in Europe employing approximately 1.36m people in England (including about 37200 managers and senior managers which represents around 2.74% of the workforce) and has an annual expenditure budget of approximately £106.6bn (NHS Confederation, 2013). Its size and complexity of operation makes it of interest to a broad range of stakeholders which include government policy formulators, practitioners, academics and the public at large.

As the largest public sector organisation in the UK the NHS is regarded as a political hot potato and is thereby subjected to constant and considerable

public scrutiny. Over the last four decades it has experienced a succession of significant politically motivated reforms which have been presented in the context of seeking to make the NHS more efficient, effective and accountable. NHS managers as change agents have been given the main responsibility for implementing and monitoring these reforms through challenging government targets and objectives. The manner in which the NHS has responded and adapted (or failed to adapt) to these reforms has attracted considerable public interest. In order to understand the significance of the various NHS reforms and the role of the NHS managers, the following section provides an overview of the historical background context relating to the events leading to the creation of the NHS and its subsequent evolution. The schematic timeline provided in Figure 1 below highlights some of the main NHS reforms which are detailed in the subsequent sections in this chapter.



**Figure 1: Schematic Timeline of the Main NHS Reforms**



### **2.2.1.1 An overview of Healthcare in Pre-NHS Britain**

Healthcare in pre-NHS Britain was market driven with medical practitioners and hospitals operating in competition with each other. Market forces and financial factors superseded any charitable national desire to provide healthcare as a natural right of every citizen. In the early part of the twentieth century and in the period between the two world wars healthcare in the UK was provided by private general practitioners and self-funding voluntary hospitals which worked in a "medical market", raised their own funds, and worked in competition with each other (Greener, 2009). The voluntary hospitals dominated acute care services at the time in Britain (Webster, 1995) but by the 1930s the voluntary hospitals (especially those which ran prestigious medical schools) were facing serious difficulties in remaining economically viable, and therefore local authorities began to invest in setting up local authority hospitals which did not work in a competitive market. Despite these efforts in December 1938 The Times in an editorial wrote of "a position so grave that the breakdown of the whole voluntary system looms on our horizon" (ibid.). Hospital services were unevenly distributed, inadequately funded and lacked co-ordination (Godber, 1988) and it was clear by the end of the Second World War that the healthcare structure had to change. The Beveridge report, published in December 1942, was the single most important document associated with this change and paved the way for the formulation of the NHS (Webster, 1992).

#### **2.2.1.1.1 The Birth of the NHS & a Summary of its Early Evolution: 1948 – 1970**

On the 5th of July 1948 under the stewardship of Aneurin Bevan, the then Labour Health Minister, the NHS came into being with the intention of

providing "free health care for all from cradle to grave". In the first phase 2,751 hospitals came under the control of the new Regional Health Boards (RHBs) (Mercer, 1988). Decision making in the NHS at that time was based mainly on "consensus management" between the doctors, nurses and administrators with the hospital consultants exercising overall control in decision making (Greener, 2009). Despite the consideration of alternative more management focused structures in the interests of increasing the efficiency and effectiveness of the NHS, the NHS did not experience any significant structural reforms for the next quarter of a century and decision making power remained the main prerogative of the hospital consultants.

#### **2.2.1.1.2 A Summary of the Development of the NHS: 1970s and 1980s**

With the election of a Conservative government in 1979 Margaret Thatcher became prime minister and the Conservative government's philosophy was to radically transform the public sector in line with the new managerialist agenda. The objective was to shift the focus of delivery within the entire public sector towards increasing the effectiveness, quality and efficiency of services to the consumer (Maybin & Thorlby, 2010). In line with this the main focus in the NHS also changed towards the provision of a more patient-centred and patient-responsive service managed within a business-like approach by clearly identified line managers (DHSS, 1983). In 1979 a consultative paper on the structure and management of the NHS entitled "Patients First" advocated a major shift away from the Keynesian public service model of an expanding centrally funded service provision to a decentralised one. This was proposed to be achieved through the simplification of the organisation structure and the encouragement of local decision making.

In line with this the government commissioned Roy Griffiths, a senior Sainsbury executive, to look at management in the NHS and his report (DHSS, 1983) which was subsequently implemented introduced “General Managers” at Regional, District and Unit levels. This "line management" supplanted the existing "consensus management" by multi-disciplinary teams of officers from many professional groups (Black, 1995). As Townsend et al. (1988, p. 24) put it "the Griffiths team was struck by what it saw as an apparent lack of clearly identified leaders and lines of management authority". In a frequently quoted passage they wrote "if Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge" (ibid.). The prescription in the 1980s was to reduce costs and increase efficiency in the NHS through the introduction of a large tier of General Managers and line managers who were given the main management and decision making powers (Pollitt, 1990).

Managers therefore gained a prominent status in the NHS and managerialism became the favoured agenda within the NHS. Prior to this process of managerialism the NHS was deemed by the then government to run in an inefficient, bureaucratic manner with little regard for cost cutting measures or efficiency and through the introduction of tight managerial control at various levels throughout the NHS, managerialism aimed to replace this perceived inefficient approach with one based on a more economic and rationalist model in order to achieve the desired objectives of efficiency and effectiveness and greater accountability to the government (Thompson & McHugh, 1995). This agenda of managerialism became known as the “New Public Management” (NPM) and was typical

of the government's broader approach towards making all public services more efficient and effective (Greener, 2009).

#### **2.2.1.1.3 A Summary of the Development of the NHS: 1990s to 2010**

Up until the 1980s the government's approach to running the public sector was mainly focused upon controlling public expenditure, costs and inputs. The emphasis shifted significantly in the 1990s towards one seeking instrumental objectives of economy, efficiency and effectiveness (Farnham & Horton, 1993).

In 1989 a major White Paper entitled "Working for Patients" was published (DHSS, 1989) with the intent to create a market in which the hospitals (providers of health care) competed with one another to win contracts from District Health Authorities (DHAs). The contracts would enable the DHAs to increase their control over the amount and quality of healthcare delivery, while the competition would encourage hospitals to reduce their costs but at the same time aim to maintain the delivery of sufficient quality care (Morgan & Potter, 1995). This White Paper contained revolutionary proposals which included allowing hospitals to apply for self-governing status as "NHS Hospital Trusts". The White Paper obliged hospitals to compete for patients by separating the "Provider" role of the hospital from the "Purchaser" role of the health authority. General Practitioners (GPs) were encouraged to hold their own budgets and to purchase healthcare for their patients. Consequently the NHS no longer enjoyed its cushioned protection from market forces as politicians and policy makers sought to achieve cost cutting and efficiency from the NHS through exposing it to quasi market forces (Best et al., 1994). A split between the "Purchasers" and "Providers" of healthcare effectively created an internal market within the NHS designed to determine resource allocation and encourage greater

efficiency within the NHS. Whilst this internal market led to improved efficiencies within the NHS, it also generated considerable challenges and difficulties for the NHS. These included the creation of significant bureaucracy in order to facilitate the workings of the internal market. Furthermore whilst the internal market was designed to create greater equity in terms of the balance of power between the purchasers and providers of healthcare, the overall balance of power still favoured the purchasers rather than the providers of healthcare (Maybin & Thorlby, 2010). Although these reforms improved the efficiency and effectiveness of patient care within the NHS, the increasing length of patient waiting times remained a concern as did the extent of variation in the standard of treatment provided by the NHS in different parts of the country (ibid.).

Even as this complex web of reforms was being implemented the entire political picture changed with the electoral defeat of the Conservatives and the election of the New Labour government in 1997. The new government started by dismantling the internal market created by the previous government and replaced it with a system of “integrated healthcare” through a more collaborative rather than the competitive approach which had previously underpinned the ethos of the internal market. This was achieved through abolishing GP fundholding and replacing this with a system in which GPs and Health Authorities co-operated together as "Commissioning Groups" in order to determine which health services to purchase. The 1997 White Paper (Dept. of Health, 1997) abolished the internal market and reorganised Health Authority functions into Primary Care Groups (PCGs) and Primary Care Trusts (PCTs). Under the new government the NHS experienced record and sustained long term investment designed to improve productivity and efficiency through the

setting of challenging government led targets aimed at making the NHS even more transparent and accountable (Maybin & Thorlby, 2010).

Through focusing upon a drive to make the NHS more patient centred and focused, the reforms also succeeded in substantially reducing patient waiting lists (ibid.).

The 1997 White Paper (Dept. of Health, 1997) also introduced Primary Care Trusts (PCTs ) which represented a developed stage of the PCGs. PCTs were directly accountable to the government via the health authority and were required to produce annual accounts. They had the legal capacity to act as both purchasers and providers of healthcare for patients and a PCT was granted legal status as long as there was local consensus among GPs, nurses and the local community for its functions. PCTs differed depending upon the function that they were intended to serve in their community and on this basis NHS Trusts were broadly divided into Acute Care Trusts (i.e. a Trust where hospitals ran Accident & Emergency departments, acute in-patient services and out-patient services all within the physical confines of the hospitals) and Community Care Trusts (i.e. where the Trust concentrated on providing intermediate and long term care to patients within the community such as community psychiatry, geriatrics and paediatrics). The government also encouraged local NHS Trusts to attain “Foundation Trust” status which allowed them greater autonomy in controlling their budgets and determining how they were to be run (Greener, 2009). Additionally the government strategy strongly encouraged public involvement in the NHS through ensuring that members of the public were elected onto the boards and committees of NHS Trusts. The motive was to provide the public with a stronger representation so as to

ensure that the NHS focused upon dealing with and meeting local needs (Birchall, 2003).

At the same time the National Institute of Clinical Excellence (NICE) and the Commission of Health Improvement (CHIMP) were set up to give high priority to “Clinical Governance” which was defined as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Health Service Circular, 1998). Clinical Governance as set up by the Health Act 1999 was a system which required NHS organisations to ensure that high quality healthcare was provided to patients and that this was continuously improved and monitored. The need for Clinical Governance had become clear as a result of a number of clinical errors and malpractice in the 1990s (such as the scandal involving the paediatric cardiovascular unit at the Bristol Royal Infirmary) which led to wide negative media coverage (Salter, 2004). Clinical Governance aimed to provide a regulatory framework for governing clinical activities and to ensure that quality care was delivered throughout the NHS by the provision of clear quality guidelines. The role of NICE was to provide the NHS with quality evidence-based guidelines relating to cost-effective drugs and treatments available whilst the main function of CHIMP was to monitor and implement these guidelines (Greener, 2009).

During this period the NHS also experienced significant and sustained long term investment including expansion and the development of new hospitals through a system of “Private-Finance Initiatives” (PFIs) (Pollock, 2004). This involved the development of new buildings and hospitals financed by the private sector for use by the NHS for an agreed and extendable period

of time (Asenova & Beck, 2003). Independent sector treatment sectors (ISTCs) were also introduced which were privately owned but also provided exclusive treatment and care to NHS patients in order to reduce waiting times (Naylor & Gregory, 2009). Apart from investing in infrastructure, the New Labour government also invested heavily in the NHS workforce. Average staff pay within the public health sector rose by nearly 75% in cash terms between 1997/8 and 2007/8 and the NHS recruited significantly more clinical and non-clinical staff (Maybin & Thorlby, 2010).

The various NHS reforms introduced under the New Labour government resulted in considerable benefits which included a major reduction in patient waiting times. Most patients were able to access their GP services within 48 hours after making contact and received NHS treatment within 18 weeks of being referred by their GPs (*ibid.*). The steadily increasing public satisfaction with the NHS was lauded as testimony to the effective management of the NHS under the New Labour government (*ibid.*). On the other hand the reforms were also criticised for their short comings. Areas such as a significant increase in bureaucracy required to facilitate the implementation and monitoring of government led targets and the top-down target led system driven by the government which contributed to the development of a “targets and terror” and a “fear and blame” NHS managerial culture were cited as some of the main criticisms of the reforms (*ibid.*). For example a report on the failures of the emergency services at Mid Staffordshire NHS Foundation Trust concluded the quality of patient services had been compromised in favour of ensuring the development of centralised processes and achievement of government based targets (*ibid.*, Wood, 2013).



#### **2.2.1.1.4 A Summary of the Development of the NHS under the Present Government: 2010 to Present**

Under the leadership of the current Conservative-Liberal coalition government elected in 2010, the NHS is once again subjected to significant radical reforms as a direct result of the implementation of the Health and Social Care Act 2012. These reforms particularly stand out in that they have been referred to as “different in both scope and intent from anything to which the NHS has previously been subjected” (Hunter, 2013, p.1) and “the largest set of changes the NHS in England has seen since its formation” (Edwards, 2013, p.1). Sir David Nicholson, the Chief Executive of the NHS, went even further by describing the scale of these reforms to be such that they can be seen “from space” (BBC News, 2013). Although there appears to be some confusion about some of the details relating to these reforms (Godlee, 2013) the government rhetoric suggests that these reforms are aimed at further embedding the values related to free market competition within the NHS in order to reduce costs, increase efficiency and improve patient care. Conversely others believe these reforms mark the beginning of the irreversible privatisation of the NHS (Hunter, 2013; BMJ Observations, 2013). Although the finer and more detailed rules of the system relating to the implementation of the Health and Social Care Act 2012 are still being worked upon (Edwards, 2013) the main thrust of the reforms involves the transfer of power and authority from April 2013 for the purchasing of healthcare services from Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) to the Commissioning Board (CB) and the Clinical Commissioning Groups (CCGs). The existing 10 SHAs and 152 PCTs have been replaced by 211 CCGs, 27 area teams, 23 clinical support units, 12 clinical senates, 13 local education and training boards and

152 health and wellbeing boards (Health & Social Care Act 2012). The 211 CCGs which are made up of a consortium of groups of GP have been given the main responsibility (along with the CB) to manage the NHS budget and purchase healthcare services from the private and public sectors (BBC News, 2013). More specifically the CB and the CCGs have been given the main responsibility for purchasing all acute and community care based health services from private and public sector organisations through competitive tendering overseen by the “Monitor” who is appointed by the government as the competition regulator. Those organisations demonstrating the ability to provide value to the NHS through reduced costs, increased efficiency and improved patient care will secure contracts from the CB and the CCGs. The rationale for making CCGs instrumental in the planning and purchasing of patient health services is based on the current government’s aim of saving £20bn in NHS costs (Ham, 2012) through reducing unnecessary bureaucracy, increasing efficiency and improving patient care and treatment. This is to be primarily achieved through devolving power and authority to GPs who are considered to be best placed to understand their patients’ needs and therefore able to determine the planning and purchasing of appropriate and effective local health services for their patients. Whilst this rationale has underpinned much of the basis for the government to drive the current reforms forward there have also been many reservations and concerns in relation to these reforms. For example concerns have been highlighted regarding specific issues such as the lack of leadership and expertise required for the practical implementation of such large scale changes (Ham, 2012; Edwards, 2013). Additionally others regards these reforms as an attack on the NHS underpinned by an ideological view aimed at beginning the “irreversible privatisation” of the NHS (BMJ Observations, 2013). This latter viewpoint

is based on the belief that these reforms are designed to lead to a situation within the NHS where “the public sector will shrink away, and the private sector will grow” (ibid.). Whilst such concerns and debates look likely to continue for quite some time, the extent to which these reforms achieve the government’s aims of reducing costs, increasing efficiency and improving overall patient care will only be known in due course.

Whilst this section has provided an overview of the NHS from its birth to the present day, the next section outlines the development of the role and significance of NHS managers within the NHS.

### **2.2.2 NHS Managers**

The last three decades has seen the management function within the NHS catapulted to considerable prominence with a significant increase evident in the numbers of managers working in the NHS. Whilst statistically the total number of managers in the NHS only represents about 2.74% of the total NHS workforce and the management budget utilises only 4% of the total NHS budget, there had been an increase of 69% in the number of managers in the NHS since 1995 to 2003 compared to 30% in the recruitment of doctors and 22% in nurses in the same period (NHS workforce census, 2003).

NHS managers perform a critical role in ensuring the implementation and achievement of government led NHS targets so as to maintain an efficient, effective and accountable organisation. As outlined earlier in this chapter<sup>6</sup> prior to the advent of managerialism within the NHS (Pollitt, 1990), decision making was influenced through “consensus management” by the various professional groups within the NHS (Black, 1995). This system

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<sup>6</sup> See section 2.2.1.1.1.

however came under constant criticism for being inefficient, wasteful of resources and lacking in professional management and direction (Dawson & Dargie, 2002). In order to rectify this the Conservative government under the leadership of Margaret Thatcher in the early 1980s commissioned Roy Griffiths, a senior Sainsbury executive, to look at management in the NHS. His report (DHSS, 1983) resulted in the introduction of General Managers at Regional, District and Unit levels. As Townsend et al. (1988, p. 24) put it “the Griffiths team was struck by what it saw as an apparent lack of clearly identified leaders and lines of management authority”. The introduction of “line management” by the Griffiths report created a new more powerful cadre of managers who were given the strategic role of change agents within the NHS (Currie, 1997; Currie, 1998). This approach was in harmony with the ideology associated with the evolution of the “New Public Management” movement<sup>7</sup> in the UK at the time (Ferlie et al., 1996; Osborne & McLaughlin, 2002).

The prescription in the 1980s was to reinforce the authority of this new cadre of managers with a battery of reviews and performance indicators and eventually to introduce the competitive incentives of an internal market (Pollitt, 1990; Ham, 1997) and to change the culture of the NHS such that it was more “business-like” (Baggott, 1997; Ham, 1997). The main intention of the government reforms then was to create an internal competitive market and highlight the significance of value for money and tight financial control (Pettigrew et al., 1992). Whilst the last Labour government introduced measures to reverse the competitive elements of the internal market within the NHS in favour of a more collaborative approach, the current coalition government has continued the emphasis of making the

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<sup>7</sup> As explained in section 2.2.1.1.2.

NHS more effective, efficient, accountable and business-like while at the same time devolving more decision making powers to local levels. This is to be achieved through shifting the locus of power away from local health authorities and managers towards GPs who will take over the role of the main purchasers of healthcare for their patients and who will also have significant autonomy in managing their local budgets.

NHS managers continue to play an instrumental role in the NHS as they have been given the main responsibility and authority to manage the NHS effectively in order to make it increasingly more efficient, accountable and business-like. On the other hand whilst the NHS managers have been given the responsibility for achieving challenging targets and objectives, they are often also regarded as punch-bags by many of the key stakeholders within the NHS. For instance policy makers often tend to be quick to engage in “manager bashing” through pointing the finger of blame on NHS managers for shortfalls and failures in achieving the various government led NHS reforms while clinicians tend to view managers as obstacles in the provision and delivery of optimum healthcare (Flanagan, 1997).

Furthermore the general public also regard NHS managers as uncaring faceless men in grey suits draining the NHS of much needed resources through their over inflated salaries (Learmonth, 1997). This manager-bashing has been further fuelled by the publicised increase in the number of managers recruited to work within the NHS over the last two decades or so. Less publicised was the information that the NHS was building management capacity from a historically low base (NHS workforce census, 2003).

It is in these contexts that NHS managers appear to have become increasingly unpopular with the general public which is a view supported

by Learmonth (1997, p. 219) who concluded that “it could be that there is a commonly held view by members of the public that a service which managers are trying to make ever more efficient, rational and controlled cannot at the same time be caring and people centred”. Despite action by managers to overtly oppose generally unpopular government reforms such as the Private Finance Initiatives (which were perceived to further emphasise and embed market values within the NHS) (Ruane, 2000), the NHS managers have still been unable to evoke public sympathy and support. Even amongst their clinical colleagues NHS managers are often viewed with disdain as reported in a study by Brown et al. who stated “clinicians gave the opinion that the priority of most managers is not the welfare of the patients...” (1994, p.67). Furthermore it could also be argued that the generally negative public perception of NHS managers is also fuelled by public government attacks upon NHS managers as convenient scapegoats for the lack of success of some of the reforms (Warden, 1995). Testimony to this is the public NHS manager-bashing carried out regularly by politicians over the years (Flanagan, 1997; Ham, 1997). The recent publication of the Francis report (2013) which made recommendations stemming from the Mid-Staffordshire scandal has also reinforced the public’s negative view of NHS managers since this report is particularly damning of the various management inadequacies and incompetencies it claims are typical of the NHS culture.

In a paper studying the NHS managers' own perceptions of how others saw their role, Preston & Loan-Clarke (2000) concluded that managers are very aware of their largely negative public perception. Learmonth (1997, p. 214) quotes from an interview with a NHS chief executive who said "people used to think we did an admirable if rather humdrum job...now they think

we're all fat cats...". Learmonth (ibid.) goes on to state that the ideology of managerialism is in general unpopular with the public who regard the traditional core values of the NHS as being violated by the efficiency seeking, cost cutting ethos of neo-Taylorist managers. In an effort to reverse these views there has been an increasing trend in the NHS over the last two decades to appoint Clinical Directors (Willcocks, 1997) and Nurse Managers, who are qualified clinicians, to take on managerial functions and responsibilities thereby blurring the distinctive managerial and clinical divide.

The present government's recent reforms seek to significantly reduce the layers of bureaucracy within the NHS. In fact the Health and Social Care Act 2012<sup>8</sup> aims to reduce management costs by about 50% mainly through management redundancies in a bid to cut bureaucracy and redirect resources into front line clinical services (Ham, 2012). These significant management redundancies could be interpreted to be a further direct government attack upon NHS managers and a clear display of the lack of recognition of their value and useful contribution to the NHS.

A more detailed outline of the extent of the NHS managers' commitment and contribution to the NHS is provided in chapter 3<sup>9</sup>.

### **2.3 The UK Private Healthcare Sector**

The UK private healthcare system has been in existence long before the formation of the NHS and although the publicly funded NHS now dominates the UK healthcare sector, a relatively small but expanding

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<sup>8</sup> See section 2.2.1.1.4 for an outline of this Act.

<sup>9</sup> See sections 3.2.7 and 3.2.8.

private healthcare sector co-exists alongside the NHS to serve needs of those able and willing to pay for their healthcare needs. The comparative scale of the private healthcare sector in relation to the publically funded NHS system is evidenced by the 83:17 percentage ratio of public to private healthcare spending in the UK (Klein, 2005). Whilst comprehensive data relating to the UK private healthcare sector is generally difficult to identify because no central organisation or authority is responsible for collating data from the numerous private healthcare providers, the overall private UK health sector income is estimated to be £3.2bn (Private Health Advice, 2013). Interestingly although the NHS represents the UK public healthcare sector it also dominates the UK private healthcare sector as it has the largest number of private patient beds sited within NHS hospitals. Only about 11,200 private patient beds are provided by independent UK private hospitals of which the largest proportion of private sector beds exist in private nursing homes (ibid.). The main providers of private healthcare in the UK are BUPA, AXA, HCA International, PPP Healthcare Nuffield and BMI Healthcare (ibid.; Sun & Wang, 2007). Of these BUPA is regarded as the main giant with 40,000 members of staff and 35 BUPA hospitals (Sun & Wang, 2007). The exclusively private UK healthcare market comprises mainly of independent hospitals, nursing homes and voluntary organisations and unlike the NHS, the main function of these private healthcare organisations is to generate a profit for the benefit of the organisation and its shareholders.

Over the last five years the UK private healthcare sector has increased in size and the majority of the UK private healthcare sector income for acute services is derived from private insurance schemes which almost trebled from 1,292,000 in 1979 to 3,685,000 in 2000 (Klein, 2005). Approximately



20% of treatments in private hospitals are self-financed by patients and the proportion of the UK population covered by private insurance schemes rose from 5% in 1980 to 11.5% in 2000 (Laing, 2001; Klein, 2005). Although during the recession spending by patients on private healthcare dropped from £520m in 2007 to £515m in 2008, it has since recovered and grew by 3.2% in 2011 (Private Health Advice, 2013). This recent increase in private insurance schemes has partly been attributed to a greater number of patients turning away from the NHS, not because of any significant criticism with the provision of the quality of healthcare provided by the NHS, but in order to avoid some of the increasingly longer waiting times prevalent in the NHS especially for non-urgent treatments and procedures (ibid.).

The current round of NHS reforms triggered by the Health and Social Care Act 2012<sup>10</sup> are likely to result in even more growth within the private healthcare sector due to competitive tendering (which includes private healthcare competition) introduced by this Act. It is predicted that the future of the UK private healthcare market looks even rosier than before and it is anticipated that the private healthcare market will grow at an average annual rate of above 5% between 2012 and 2016 (Private Healthcare Market Report, 2013). Whilst the intention of the Act is to provide patients with better value and quality of care, some predict that this will lead to a situation within the NHS in which “the public sector will shrink away, and the private sector will grow” (BMJ Observations, 2013). Despite these optimistic views of the UK private healthcare sector, Damien Marmion the managing director of Bupa has recently cautioned against complacency in the private healthcare market and warned that “the private healthcare sector must improve the quality of its services, cut its costs, and

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<sup>10</sup> See section 2.2.1.1.4 for an outline of this Act.

increase transparency to demonstrate value to consumers if it is to thrive” (Torjesen, 2013, p. 1).

In terms of employment about half a million people work in the private health sector which equates to about a quarter of the total workforce in the UK healthcare sector. Whilst 21% of healthcare professional are employed exclusively within the private healthcare sector, a majority of clinical healthcare professionals (especially hospital consultants) work in both the NHS and the private healthcare sector (Private Health Advice, 2013).

Although there is abundant statistical data available regarding the breakdown of the various categories of staff employed by the NHS (including NHS managers), there does not appear to be similar comprehensive data available for the UK private healthcare sector due to the lack of a central organisation or authority responsible for collating data from the numerous commercially separate private healthcare providers. As far as private healthcare managers are concerned, like their NHS counterparts, they are charged with the responsibility to achieve performance targets through ensuring the efficiency and effectiveness of their private hospitals. However unlike their NHS counterparts, private healthcare managers are also charged with ensuring that their hospitals remain profitable and competitive.

## **2.4 Concluding Observations**

This chapter has provided background information relating to the UK healthcare market which consists of both the public and private healthcare sectors. The chapter gives a historical account of the various major government led NHS reforms over the last few decades and outlines their

impact upon the NHS. Whilst the various government led reforms over the last few decades have aimed to make the NHS more efficient and effective they have been inevitably shaped and influenced by the political ideologies of the government of the day. The pivotal role played by NHS managers in relation to both their day to day management functions and their central role as change agents responsible for the effective implementation of numerous government led reforms has also been highlighted in this chapter. Additionally the role of the UK private healthcare sector which co-exists alongside the NHS and is a relatively small but expanding sector has been outlined in this chapter. The next chapter provides a literature review of the main theoretical framework underpinning this study.

## **Chapter 3: Literature Review**

### **3.1 Introduction**

As indicated in the first chapter the aim of this study is to “critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21<sup>st</sup> century NHS managers”. Furthermore four specific objectives have been identified to support the achievement of this aim. The first objective which is “to identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner” has essentially been designed in order to develop an insight into the NHS managers’ core values and their managerial culture. An examination of theories related to Organisation Culture is obviously important in this context. The second objective relates “to exploring the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”. This objective draws upon New Institutional Theory as a valuable background theoretical framework and context from which to explore the NHS managers’ perceived public image. The third objective which focuses upon “exploring the healthcare managers’ self and work identities” is underpinned by the theoretical framework related to Self and Work Identity. The final objective which aims to “to critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers” draws upon the theoretical framework related to the concept of Corporate Social Responsibility.

This chapter is therefore structured around developing a critical literature review of Organisation Culture, New Institutional Theory, Self and Work Identity and Corporate Social Responsibility which make up the theoretical foundations underpinning this study. An understanding of these relatively disparate fields of study provides a valuable overarching framework when drawn upon in an integrated manner to explore and discuss the findings emerging from this study so as to develop a more holistic and deeper understanding of the issues central to the aim and objectives of the study.

The following section begins with a critical literature review relating to Organisation Culture which underpins the first objective driving this study.

## **3.2 Organisation Culture**

### **3.2.1 Introduction**

The first objective of this study<sup>11</sup> seeks to “identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner”. An exploration of the core values held by the NHS managers involved in this study should provide an insight into the NHS managerial culture since as explained by Smith (2000, p.153) the "conventional view of (organisation) culture centres on notions of shared values and beliefs".

It would be useful at this stage to highlight why the study of the concept of “Organisation Culture” and “core values” is deemed to be significant in relation to the aim and objective of this study so as to set the background context for the ensuing literature review.

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<sup>11</sup> As stated in section 1.3.

Whilst, as explored later in this chapter, there exist a myriad of definitions relating to the concept of Organisation Culture, it is generally recognised amongst leading writers in this field that an understanding of this concept is fundamental for developing an insight into the complex dynamics of organisation life. Schein (1985, p. 3) for instance underscores this point when he writes that “unless we learn to analyse organizational cultures accurately, we cannot really understand why organizations do some of the things they do...”, whilst Hatch (1997, p. 204) also emphasises this point when she writes “organization culture usually refers to the way of life in an organization”. Furthermore Barley (1991, p. 39) regards Organisation Culture to provide an “interpretive framework that undergirds daily life”. Since NHS managers play an instrumental role as change agents within the NHS<sup>12</sup>, their contribution and commitment to the NHS in turn is central to the effective and efficient delivery of high quality patient care by the NHS. Given this central and significant role of NHS managers, an understanding of the NHS managerial culture should provide a valuable insight into the complex dynamics underpinning the managers’ day to day organisational realities which inevitably shape and influence their overall performance and commitment to the NHS. Developing an insight into the NHS managerial culture in turn requires an understanding of the managers’ shared values and beliefs since (as explored later in this chapter) these play a critical role in shaping, guiding and influencing the work and behaviour of the NHS managers.

The next section therefore begins with providing a literature review relating to “Organisation Culture” and “Subculture” followed by a review of the

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<sup>12</sup> See section 2.2.2 for an outline of the role of NHS managers.

literature relating to the NHS Organisation Culture and the NHS Managerial culture.

### **3.2.2 Defining & Understanding Organisation Culture**

Whilst the concept of Organisation Culture is popular in the field of Organisation Theory it has been described as one of the most difficult to define (Hatch, 1997, Alvesson, 2002). The reason for this is eloquently stated by Alvesson (2002) when he writes “culture is, however, a tricky concept as it easily used to cover everything and consequently nothing” (p. 3). Although there appears to be a myriad of definitions, views and approaches towards understanding this concept, Organisation Culture has generally been recognised to be particularly significant in terms of shaping and influencing human behaviour within organisations (Peters & Waterman, 1982; Alvesson, 2002; Thompson & McHugh, 2002; Hatch with Cunliffe, 2006; Clegg et al., 2011). An examination of the relevant literature reveals that some of the definitions and approaches towards understanding Organisation Culture appear to be relatively more specific in nature than others. For example Morgan (1997, p.138) defines Organisation Culture as “shared meaning, shared understanding & shared sense-making are all different ways of describing culture”. Here the main focus appears to be upon the extent of “shared” meaning, understanding and sense-making experienced by the organisation’s employees. A similar stance is evident in the following definitions of Organisation Culture which also emphasise the notion of “shared” values and understanding amongst organisational employees: “...it is best described as a feeling which a number of people share consistently about situations in the organisation (Kakabadse et al., 2005, p.189); “a system of shared meaning held by (organization) members” (Robbins, 2003, p.525) and “a pattern of basic assumptions -

invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration...” (Schein, 1985, p. 9). This can be contrasted with relatively broader definitions and approaches towards understanding Organisation Culture such as those adopted by Pacanowsky & O’Donell-Trujillo (1983, p.146) who write “Organizational Culture is not just another piece of the puzzle, it *is* the puzzle” and Deal & Kennedy (1982, p. 4) who recognise Organisation Culture to be “the way we do things around here”. Irrespective of the overall stance adopted towards understanding this concept, a review of much of the literature on Organisation Culture demonstrates that the notions of “shared values”, “shared assumptions”, “shared meaning” and “common perception” tend to either implicitly or explicitly underpin many of the definitions (Schein, 1985; Morgan, 1997; Robbins, 2003; Kakabadse et al., 2005). Those organisations that demonstrate a cohesive and unified set of shared core values are recognised as having “strong” organisation cultures whilst the reverse is deemed true for those organisations identified as having relatively “weak” Organisation Cultures (Rosenfeld & Wilson, 1999). It is also widely held that strong Organisation Cultures, due to their cohesive unified set of core values, are likely to engender greater employee commitment and are thereby more prone towards yielding higher productivity, effectiveness and profitability than their weaker counterparts (ibid.).

Whilst developing an insight into an Organisation’s Culture requires an understanding of the shared core values and beliefs held by the employees within an organisation some researchers have also highlighted the interplay of “external” influences upon the culture of an organisation. These include the influence of national cultural dimensions upon the culture of an



organisation (Hofstede, 1997)<sup>13</sup>. Furthermore since organisation members can also be members of other external institutions such as professional bodies it has been held that these bodies also shape and influence the values and beliefs of its members so as to create a strong sense of identity amongst its members (Freidson, 1970, Carney, 2006). Such shared professional norms inevitably mould the values of the members of an organisation and the culture of an organisation can thereby also be deemed to be shaped and influenced by external institutions.

### **3.2.3 Organisation Culture & Theoretical Perspectives**

The complexity of the concept of Organisation Culture is further compounded by the differing views and approaches adopted towards understanding this concept from different theoretical perspectives<sup>14</sup> based on their ontological and epistemological positions and an understanding of some of these theoretical perspectives would be useful at this stage. For example when attempting to provide a synthesis of the multitude of approaches and definitions related to this concept, Smircich (1983) identifies two distinct viewpoints – i.e. Organisation Culture is viewed either as a “variable” or as a “root metaphor”. Functionalists, based on their ontological assumption that reality is objective, tend to adopt the former position and from this perspective seek to provide managers with “tool kits” designed to enable them to (re)shape their Organisation Culture in order to improve organisational performance and effectiveness. On the other hand, based on the ontological position that reality is subjective and socially constructed, the interpretivists or constructivists view Organisation Culture as a “root metaphor”. This view recognises Organisation Culture as

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<sup>13</sup> See section 3.2.5.2 for an explanation of Hofstede’s (1997) national cultural dimensions.

<sup>14</sup> Crowther & Green (2004) provide a comprehensive overview of the various theoretical perspectives related to organisation theory.

something an organisation “is” rather than something an organisation “has”. Interpretivists therefore regard Organisation Culture “not mainly in economic or material terms (as in the case of the Functionalists) but in terms of their expressive, ideational and symbolic aspects” (Smircich, 1983, p. 348). By recognising that reality is socially constructed, the “root metaphor” approach aims to develop a deeper understanding of an Organisation’s Culture through identifying the shared core values held by the organisation’s members and exploring the meanings and interpretations that the members give to their day to day organisational realities and experiences. In essence therefore rather than viewing Organisation Culture as a variable to be manipulated based on the managerial “efficiency” lens of the Functionalists, the Interpretivists are more preoccupied with developing an insight into understanding the Organisation’s Culture so as to be able to make sense of the behaviour and experiences of the organisation’s members.

The assumption that organisational actors inherently share “common beliefs and values” underpinning some of the above views on Organisational Culture is not without its critics. This view has particularly attracted criticisms from Interpretivists and Postmodernists. For example according to Meyerson & Martin (1987) Organisation Culture can also be viewed through the paradigm of ambiguity whereby coalitions within the organisation are based upon agreement or disagreement on salient issues as they emerge. Consequently they argue that allegiances to cultures and subcultures<sup>15</sup> may constantly shift according to pertinent issues relevant to interested parties at the time and thereby “...individuals share some viewpoints, disagree about some and are ignorant of or indifferent to

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<sup>15</sup> The term “organisation subculture” is defined and explained in the next section (section 3.2.4).

others...individuals are temporarily connected by shared concerns..." (ibid., p. 637-8). Similarly Hatch (1997, p. 231) writes "subcultures are re-conceptualised as fleeting, issue-specific coalitions that may or may not have a similar configuration in the future" (ibid., p. 231). This approach views coalitions in a subculture as being determined according to the extent of agreement or disagreement on salient issues rather than being based on commonly accepted beliefs and values.

Whilst it is therefore clear that understanding and defining Organisational Culture is a complex issue, it is evident that an Organisation's Culture is shaped and reshaped by how individuals in groups perceive and enact their reality based on events within and outside the organisation. This therefore serves to emphasise the dynamic nature of the concept of Organisation Culture reflecting changes in the organisation and its environment.

### **3.2.4 Defining & Understanding Organisation Subculture**

Whilst the concept of "Organisation Culture" relates to the culture of a single corporate entity, the concept of "Organisation Subculture" is differentiated so as to relate to the common shared values and beliefs unique to a particular group or department within an organisation. This distinction is explained succinctly by Johnson & Gill (1993, p. 98) who define Organisation Subculture as "a subset of an organization's members who interact regularly with one another, identify themselves as a distinct group within the organization, share a set of problems commonly defined to be the problems of all, and routinely take action on the basis of collective understandings unique to the group". Similarly subcultures are considered to be distinct groups within an organisation that reflect "different interests, tastes and habits" to those of the rest of the organisation (Clegg et al., 2011

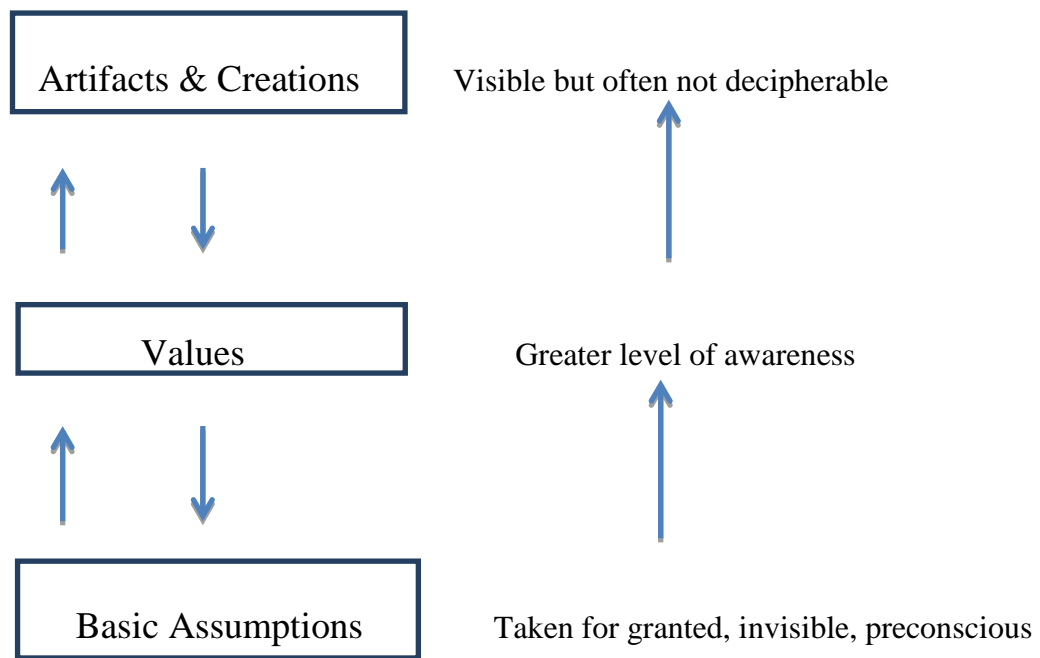
p. 237). Depending on the extent of the differentiated nature of the Organisation's Culture, an organisation can consist of multiple subcultures (Meyerson & Martin, 1987). Consequently as Martin & Seihl (1983) explain subcultures may share values which are consistent with those of the overall organisation culture or may be unique and distinct from those reflecting the dominant organisation culture. A deep and rich insight into the overall culture of the organisation is therefore more likely to be developed through seeking an understanding of the nature and extent of the various subcultures that may exist within an organisation.

### **3.2.5 Some Models & Instruments Useful For Designing, Exploring, Assessing & Changing Organisation Cultures**

Whether one views the concept of Organisation Culture as a variable or a root metaphor, a number of useful theoretical models and practical instruments have been devised to assist academics and practitioners in designing, exploring, assessing and changing organisational cultures. As explained in the following sections in this chapter some of these established and particularly popular models and instruments include Schein's model (1985), Hofstede's National Cultural Dimensions (1980), Cameron & Quinn's Competing Values Framework (1999) and Harrison's Culture Quadrant (1972).

#### **3.2.5.1 Schein's model**

Schein's (1985) model which outlines three levels of Organisation Culture is deemed to be one of the most established and renowned models within the field of Organisation Studies. As indicated in Figure 2, this model consists of three interrelated levels identified as "artifacts", "values" and "basic assumptions".



**Figure 2: Levels of Culture & Their Interaction**  
(Adapted from Schein, 1985, p. 14)

“Artifacts” tend to be easily identified and represent the surface, visible and symbolic manifestations of an Organisation’s Culture (Schein, 1985; Rosenfeld & Wilson, 1999; Clegg et al., 2011). These include the layout of the physical building, the interior design and the dress code adopted by the staff. So for example visible features of an organisation which reflect traditional separate offices for members of staff (rather than an open plan office) and where members of staff appear to be dressed formally would suggest the existence of a traditional and formal Organisational Culture.

“Values” comprise the second layer of Schein’s model (ibid.) and unlike artifacts these tend to be more difficult to identify since they are invisible and reflect the norms and beliefs espoused by the organisation’s members (Schein, 1985; Linstead et al., 2009; Rollinson with Broadfield, 2002).

Schein (1985) believes that these values “provide the day-to-day operating principles by which the members of the culture guide their behaviour” (p. 15). Similarly Clegg et al. (2011, p. 221-222) define values to “represent a non-visible facet of culture that encompasses the norms and beliefs that employees express when they discuss organizational issues”. So for example an Organisation’s Culture may have inculcated a greater sense of value amongst its members in relation to providing a friendly, flexible and approachable service to customers rather than one that is more formal and bureaucratic. As Schein (1985) explains “many values remain conscious and are explicitly articulated because they serve the normative or moral function of guiding members of the group in how they deal with certain key situations” (p. 16). An interrelationship between artifacts and values in Schein’s model (ibid.) is evident since for example the provision by an organisation of friendly customer services may be facilitated through having staff that are easily approachable and who may also be informally though smartly dressed.

The third layer of Schein’s model (ibid.) relates to “basic assumptions” which comprise the deepest layer of the Organisation’s Culture. Whilst the organisation’s employees may hold consciously determined values, basic assumptions are recognised to underpin and shape values but are less easily explored as they tend to be embedded in the subconscious elements of the individual’s mental frame (Schein, 1985; Linstead et al., 2009; Clegg et al., 2011). These assumptions are influenced by the individual’s wider cultural, social and religious worldviews which guide their behaviour through shaping their norms and values. An understanding of Hofstede’s (1997) national cultural dimensions<sup>16</sup> provides an understanding of the wider

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<sup>16</sup> See the next section (3.2.5.2) for an explanation of this.

differences in national cultural dimensions which influence and shape the individual's cultural and social framework and thereby guide their behaviour.

An exploration of each of these three levels is deemed to provide a rich and deep insight into understanding an Organisation's Culture.

### **3.2.5.2 Hofstede's National Cultural Dimensions**

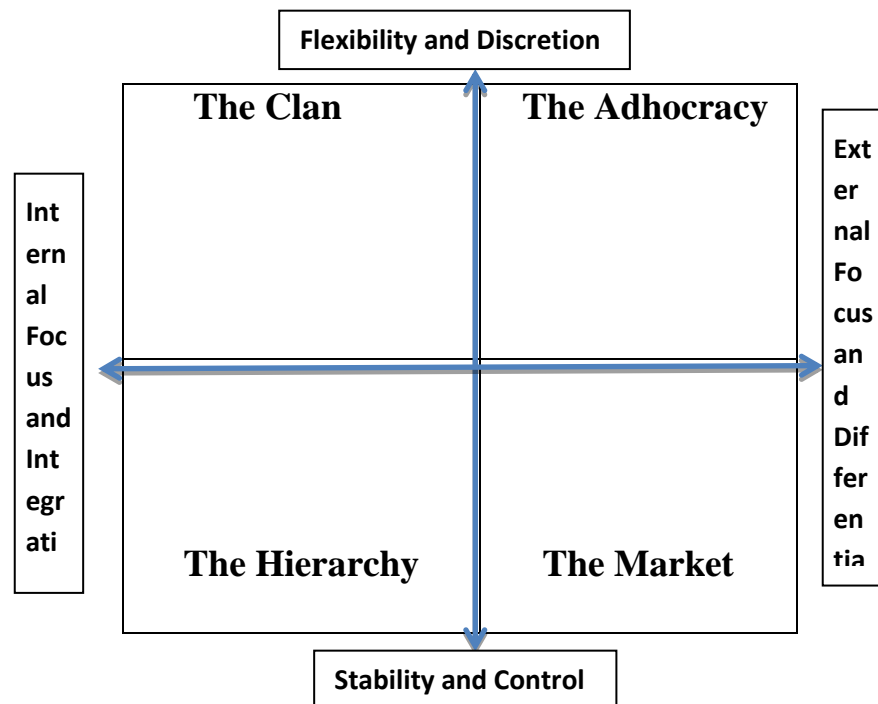
Hofstede's (1997) research work in exploring and identifying national cultural differences provides a valuable framework to locate the understanding of the concept of Organisational Culture within the broader international context. Hofstede (ibid.) and Hofstede & Bond's (1988) extensive cross-cultural research study involved collecting and analysing data from about 116,000 IBM employees working in over 50 different countries. This data identified five key dimensions of national cultural differences relating to "power distance (from small to large), collectivism versus individualism, femininity versus masculinity, uncertainty avoidance (from weak to strong) and long-term orientation in life to a short-term orientation" (Hofstede, 1997, p. 14). The "power distance" dimension reflects the extent to which members within a society accept the unequal distribution of power whilst the "collectivism/individualism" dimension reflects the extent to which members of a society favour promoting collective interests over individualist interests. The "femininity/masculinity" dimension distinguishes those values preferred by a society's members which are deemed to be masculine (such as the extent of assertiveness and competitiveness) from those deemed to be feminine (such as a concern for sensitivity and the welfare of others). "Uncertainty avoidance" relates to the extent to which the members of a society feel

insecure with out of the ordinary or uncertain situations. The “long-term/short-term orientation” is based on the Chinese Confusion dynamism principles in relation to the extent to which members of a society place emphasis on seeking virtue and value the building and cultivation of long term partnerships and relationships over those which are more short term orientated. The countries involved in Hofstede’s (1997) and Hofstede & Bond’s study (1988) were plotted on the five different dimensions to demonstrate the relative similarity or differences amongst the countries with respect to each of the dimensions. These studies provided a valuable and deeper understanding of the concept of Organisation Culture in relation to the wider national cultural differences.

### **3.2.5.3 Quinn’s Competing Values Framework**

Cameron & Quinn’s (1999) “Competing Values Framework” as shown in Figure 3 was devised to “assist individuals in better understanding an effective way to diagnose and change culture in order to enhance organizational performance” (ibid., p. 5).





**Figure 3: Competing Values Framework (Cameron & Quinn, 1999, p. 123)**

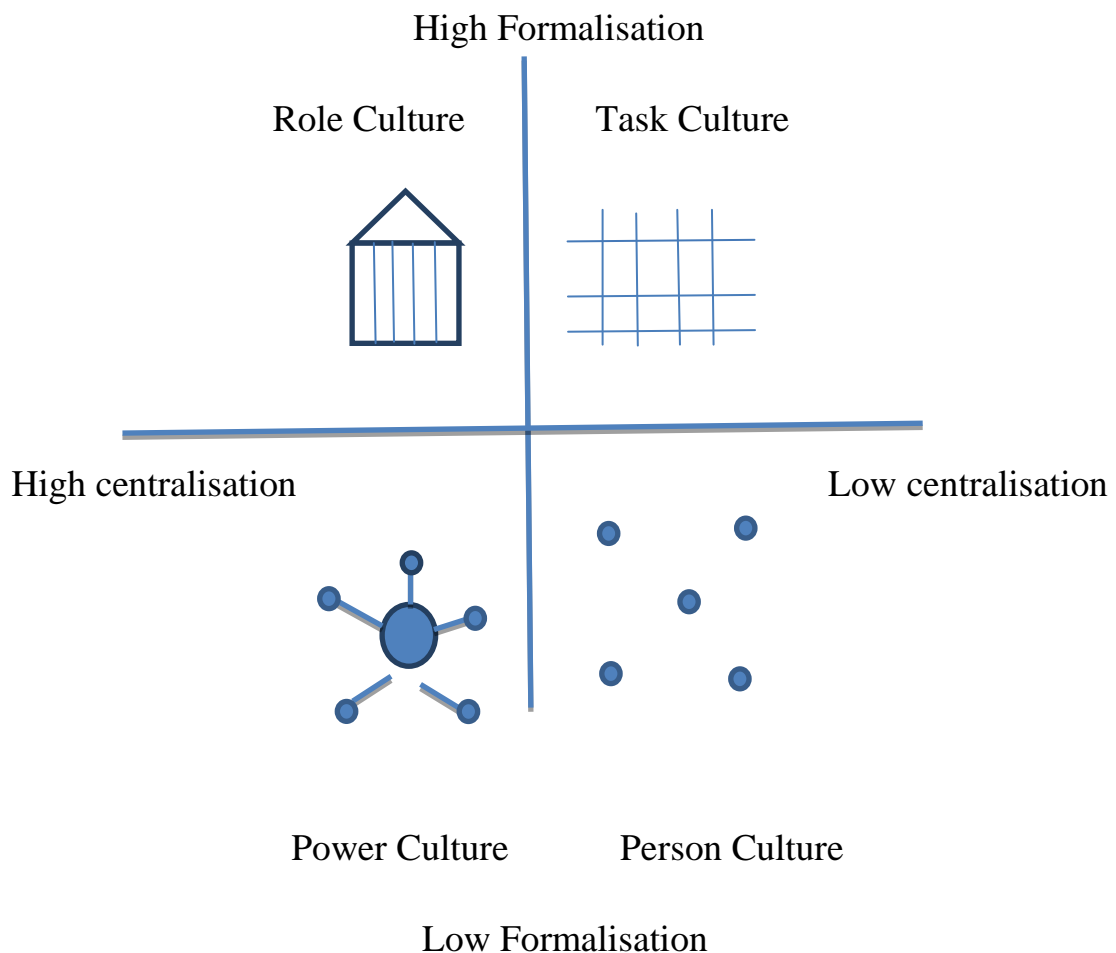
This framework is particularly useful for those who assume Organisation Culture to be a “variable” which is open to change<sup>17</sup> since it provides a basis to diagnose an Organisation’s Culture with a view to bringing about desired and planned changes to it. The framework identifies four possible dominant types of Organisation Cultures known as “Clan”, “Hierarchy”, “Adhocracy” and “Market Culture”. As show in Figure 2, the matrix representing each of these dominant types of Organisation Culture is based on two key dimensions. The horizontal dimension represents the extent to which the organisation has an internal/external focus whereas the vertical dimension reflects the extent to which an organisation has a predisposition towards flexibility or stability. The “Clan” culture has characteristics of a friendly extended family environment with an internal focus based on

<sup>17</sup> See section 3.2.3 for an explanation of this.

flexibility and where a concern for people is deemed significant with emphasis placed on teamwork, participation and consensus. Although the “Hierarchy” culture has a similar emphasis on an internal focus with integration, the concern for stability, control and predictability within this culture reflects the need for highly formalised and structured procedures regulating how work is undertaken. On the other hand whilst the “Market” culture also focuses upon the need for stability and control, its external market driven focus reflects its highly competitive, demanding and results oriented ethos. The “Adhocracy” culture in line with its external focus and the need for flexibility reflects characteristics of being a dynamic, creative and an entrepreneurial environment to work in where individuals are encouraged to take initiative and experiment with ideas.

#### **3.2.5.4 Harrison’s Culture Quadrant**

Harrison (1972, p. 121) also provides a useful model as shown in Figure 4 for differentiating between four types of Organisation Cultures identified as “Power”, “Role”, “Task” and “Person” cultures. Each of these four types of Organisation Cultures are determined according to two dimensions based on the extent of formalisation and centralisation prevalent within the organisation.



**Figure 4: Harrison's Culture Quadrant (adapted from Linstead et al., 2009, p. 164)**

As shown in Figure 4, the "Role Culture" is characterised by organisational activities determined by highly formalised rules and procedures and centralised decision making within the organisation. The "Task Culture" is characterised by a relatively more decentralised structure where a limited degree of formal policies and procedures govern organisational activities. A "Power Culture" and "Person Culture" are characterised by the existence of very few rules and procedures directing organisational activities though the former usually exists within a highly centralised structure whilst the latter type is likely to be situated in a more decentralised structure. Harrison's (ibid.) culture quadrant provides a useful framework to identify

and develop a fuller understanding of the nature of an organisation's dominant type of culture.

Whilst the preceding section highlights some of the differences in approaches and understanding relating to the concept of Organisation Culture, it is important to recognise that an Organisation's Culture is shaped and reshaped by how individuals and groups of individuals within the organisation perceive and enact their reality based on events inside and outside the organisation. The different theoretical models mentioned above reflect the diversity in approaches towards understanding and making sense of this concept.

### **3.2.6 This Study's Adopted Stance to Understanding & Exploring Organisation Culture**

How one conceptualises and seeks to understand and explore the concept of Organisation Culture is fundamentally determined according to one's ontological view and the epistemological stance adopted. As already alluded to earlier<sup>18</sup>, Smircich (1983) provides a useful framework in this respect in terms of either viewing Organisation Culture as a "variable" or a "root metaphor". Those adopting the former position invariably assume an objectivist epistemological position and thereby through adopting a Functionalist perspective view the concept of Organisation Culture as something the organisation "has" and therefore subject to managerial design and intervention. On the other hand those who recognise Organisation Culture as a "root metaphor" tend towards adopting a subjective based epistemological position through recognising that Organisation Culture is something an organisation "is" rather than "has". It

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<sup>18</sup> See section 3.2.3.

is the latter epistemological position as outlined in the methodology chapter later in this thesis which has been adopted in this study<sup>19</sup>. Instead of recognising Organisation Culture as a variable open to design and intervention this position seeks to understand Organisation Culture in terms of the extent to which it reflects the organisation's deeper symbolic and expressive nature. The adoption of an interpretive or constructive approach (ibid.) in this study lends itself towards providing the basis to develop a rich and deeper understanding of the NHS managerial culture through exploring the NHS managers' perceived core values. In line with the first objective of this study<sup>20</sup> an appreciation of the NHS managers' perceived core values in turn provides an insight into exploring the extent to which these relate to a commitment towards working in a socially responsible manner.

### **3.2.7 NHS Organisation Culture**

Since the overall aim of this study is to “critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21st century UK NHS managers”, an understanding of the NHS Organisation Culture would be a useful starting point. This will also provide the necessary background context for exploring the NHS managerial culture<sup>21</sup>.

As already outlined in chapter 2<sup>22</sup> the NHS represents the UK public healthcare sector and began its life in 1948 with the main principle of providing free care for every man, woman and child from cradle to grave

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<sup>19</sup> See section 4.2.5 which provides a rationale for the methodological position adopted in this study.

<sup>20</sup> As stated in section 1.3.

<sup>21</sup> The term “NHS managerial culture” is used synonymously with the term “NHS managerial subculture” in this thesis.

<sup>22</sup> See section 2.2.1.

(Webster, 1992). Today the NHS enjoys a world class reputation of providing free high quality care and treatment to all EU citizens and is the largest organisation in Europe employing approximately 1.36 million workers with an annual expenditure budget in the region of £106.6bn (NHS Confederation, 2013). Over the last three decades this giant organisation has undergone a succession of significant politically motivated government led reforms<sup>23</sup>. These reforms were instituted within the context of the New Public Management agenda adopted by the government and were primarily designed to implement tight managerial controls throughout the NHS in order to make the NHS ever more efficient, effective and accountable (Farnham & Horton, 1993, Best et al., 1994, Thompson & McHugh, 1995). Up until the late 1980s the government's approach to managing the public sector was to focus on controlling public expenditure, costs and inputs, however this emphasis changed in the 1990s towards seeking instrumental objectives of economy, efficiency and effectiveness (Farnham & Horton, 1993). Consequently the NHS no longer enjoyed its cushioned protection from market forces as politicians and policy makers sought to achieve cost cutting and efficiency within the NHS by exposing it to quasi market forces in order to determine resource allocation and efficiency (Best et al., 1994). This agenda of new managerialism which is also referred to under the broader New Public Management (NPM) movement was typical of the government's approach at that time in seeking to make all public services increasingly more efficient and effective in line with the managerial ethos of the private sector (Greener, 2009). As a result of numerous government led reforms, the NHS Organisation Culture has faced a series of challenges from initiatives designed to transform it into one that facilitates the increasingly relentless demand on the NHS to provide high quality care and

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<sup>23</sup> As outlined in section 2.2.1.

treatment to its patients while at the same time reducing overall costs and increasing efficiency (Department of Health, 1998; Department of Health, 2001). Consequently there have been numerous studies investigating and exploring the extent of cultural transformation within the NHS as a result of these government led reforms (Mackenzie, 1995; Hughes, 1996; Flanagan, 1997; Davies, 2002; Scott et al., 2003b; Worthington, 2004; Carney, 2006; Mannion et al., 2010; Jacobs et al., 2013).

Given the highly complex nature of the work undertaken by the NHS, it employs a number of distinct occupational groups of workers which include doctors, nurses, therapists, NHS managers, clerks, porters, cleaners and ancillary staff (Scott et al., 2003b). Consequently the NHS is deemed to be a multicultural society with each group of staff representing its own unique identity and subculture (Drife & Johnston, 1995). The clinicians had, until the early 1980s, been the most powerful group within the NHS (Scott et al., 2003b; Worthington, 2004) though this power balance changed in favour of NHS managers with the advent of new managerialism (Pollitt, 1990) within the NHS. This overall shift of managerial power away from the clinicians towards NHS managers has however been achieved at the expense of considerable resistance from the clinicians resulting in tensions between clinicians and non-clinical groups of management staff (NHS Confederation, 2002).

The diverse groups of workers employed by the NHS is reflected in the distinct subcultures within the NHS based on the values and beliefs held by the various groups which shape their identity and purpose within the organisation (Scott, 2002). These unique values and beliefs are also externally influenced for example by the allegiance that members of these subcultures may have to their affiliated professional associations (Davies,

2002). So for example as far as doctors are concerned this would relate to their membership of the relevant medical or surgical Royal Colleges whilst for the nurses this would relate to their membership of the Royal College of Nursing. Other groups of non-clinical grade staff such as managers may well hold allegiance to various professional organisations (depending on their relevant training) such as the Chartered Institute of Management (CIM) or the Association of Chartered Certified Accountants (ACCA). So as articulated by Freidson (1970) whilst clinicians will hold values which have been shaped and influenced by their professional training leading to their registration within a specialised clinical profession, they will also have been awarded an educational qualification by a relevant academic institution. On the other hand non-clinicians (such as managers and administrators) may have attained an educational qualification (such as an MBA and/or an accounting related qualification) from an appropriate academic educational institution. To complicate matters further, clinicians may have also received training in management (e.g. MBA) and have dual or mixed affiliations. The NHS has consequently been recognised to have strong subcultures underpinned by unique professional values (Scott et al., 2003a, b).

As explained in the previous chapter<sup>24</sup> whilst NHS managers have generally experienced a relative increase in their balance of power over the last quarter of a century due to the various government led reforms, their clinical colleagues have conversely experienced a decrease in their overall managerial authority over the same period of time. The political implications created by this shift in power have inevitably resulted in the development of tensions between the clinical and non-clinical groups of

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<sup>24</sup> See section 2.2.2.



workers (Drife & Johnston, 1995; Atun, 2003; Bolton, 2003; Worthington, 2004). These tensions have been particularly highlighted in the various qualitative and quantitative based studies undertaken to explore the outcomes and implications of government and local NHS Trust led reforms designed to change the culture of the NHS (Mackenzie, 1995; Davies et al., 2000; Scott et al., 2003b; Worthington, 2004; Mannion et al., 2008).

Furthermore as clinicians have increasingly occupied management positions during their careers, this has in some cases also led to tensions being expressed by them as a result of role conflict connected to their dual managerial and clinical responsibilities (Sambrook, 2006).

However as the main purpose of the NHS is to provide free high quality compassionate care and treatment to its patients, the overall NHS organisational culture is generally assumed to be implicitly underpinned by an altruistic based ethos (Mellett & Marriott, 1995; Clarke & Yarrow, 1997). Furthermore it is also generally held that NHS staff in the main share a common inherent commitment and allegiance to the altruistic ethos underpinning the NHS in terms of seeking to deliver high quality patient care. This view is supported by the findings of various studies including those undertaken by Mellett & Marriott (1995), Clarke and Yarrow (1997) and Young (1999). These studies identified that all groups of workers in the NHS share common values which support the best interests of patients though of course the extent of such commitment to patients would obviously vary depending on the core beliefs held by individual staff and the extent to which these are shared by the various organisation members. It is important here to emphasise that the view that NHS staff as public sector workers share an inherent commitment to altruistic based values is not necessarily novel or unique to the NHS but has also been established in

relation to other public sector organisations. For example a popularly cited study undertaken by Blau (1963) conducted as far back as 1949 reported that public civil servants based in the USA Employment Agency valued and derived satisfaction in “helping others in the course of (their) bureaucratic activities” (ibid., p. 84).

Having developed an overview of the NHS Organisation Culture, the next section provides an understanding of the NHS managerial subculture.

### **3.2.8 NHS Managerial Culture**

An understanding of the NHS managerial culture is fundamental to this study since the first objective of this study is “to identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner”<sup>25</sup>. This section provides a critical literature review of the NHS managerial culture in order to provide the background context for this study.

In order to develop an insight into the NHS managerial culture it would first be useful to provide some background information related to the relative increase in prominence of the role of management within the NHS<sup>26</sup>. Prior to the advent of managerialism within the NHS (Pollitt, 1990), decision making was influenced through “consensus management” by the various professional groups within the NHS (Black, 1995). Although at that time a consensus management culture characterised the approach towards decision making within the NHS, the clinicians were recognised to be the most powerful group within the NHS. Whilst the consensus management culture facilitated a collaborative approach towards the

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<sup>25</sup> As identified in section 1.3.

<sup>26</sup> As explained in section 2.2.2.

management of the NHS, this approach was constantly criticised for being inefficient, wasteful of resources and lacking in professional management and direction (Dawson & Dargie, 2002). As a result in 1983, the Thatcher government commissioned Roy Griffiths, a senior Sainsbury executive, to review the process and role of management within the NHS and his report (DHSS, 1983)<sup>27</sup> which was subsequently implemented, introduced General Managers at Regional, District and Unit levels. As Townsend et al. (1988, p.24) put it “the Griffiths team was struck by what it saw as an apparent lack of clearly identified leaders and lines of management authority”. The introduction of “line management” by the Griffiths report created a new more powerful cadre of managers who were given the “strategic role of change agents (within the NHS)” (Currie, 1997, p. 304). This approach was in harmony with the ideology associated with the evolution of the New Public Management movement in the UK at the time (Ferlie et al., 1996; Osborne & McLaughlin, 2002). The prescription in the 1980s was to reinforce the authority of this new cadre of managers with a battery of reviews and performance indicators and eventually to introduce the competitive incentives of an internal market (Pollitt, 1990; Ham, 1997) and to change the culture of the NHS such that it was more business-like (Baggott, 1997; Ham, 1997). The intention at the time was to also highlight the significance of value for money and financial control (Pettigrew et al., 1992).

Presently there are about 37,200 managers within the NHS which represents approximately 2.74% of the total NHS workforce (NHS Confederation, 2013). The NHS managers, as the main change agents, have been given the responsibility for the administration and implementation of

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<sup>27</sup> See section 2.2.2.

the various government led reforms aimed at making the NHS more efficient, effective, accountable and business like. Consequently new managerialism within the NHS has resulted in a shift in the balance of power away from the clinicians in favour of the NHS managers such that “rather than simply supporting medical staff to satisfy their resource needs, their (the NHS managers’) responsibility is to work “with”, not “for” doctors to help modernise the NHS” (Worthington, 2004, p. 55). NHS managers therefore gained considerable power and thereby play a much more influential role in the “planning, decision making and cost control over the use of resources and the training and development of healthcare professionals” (ibid., p. 57). This overall shift of managerial power from the clinicians to NHS managers has however been achieved at the expense of considerable resistance from the clinicians and the consequent development of political tensions between clinicians and non-clinical groups of management staff (NHS Confederation, 2002). Although the role of NHS managers is fundamental to the provision of effective and efficient delivery of healthcare, there are currently plans underway as a result of the reforms associated with the Health & Social Care Act (2012) to reduce management costs by about 50% mainly through management redundancies in order to cut bureaucracy and redirect resources to front line services (Ham, 2012). It is however envisaged that NHS managers will continue to play a crucial role in managing the effective and efficient delivery of healthcare services within the future of the NHS.

Whilst there have been numerous studies exploring aspects related to the NHS Organisation Culture and more specifically the NHS managerial culture (Mellett & Marriott, 1995; Clarke & Yarrow, 1997; Currie, 1997; Learmonth, 1997; Soderlund et al., 1997; Flanagan, 1997; Ham, 1997;

Jackson, 1997; Willcocks, 1997; Young, 1999; Dawson & Dargie, 2002; Scott et al., 2003a,b), most of these studies have tended to adopt a predominantly quantitative and positivist approach towards the exploration and analysis of the issues related to the NHS organisation culture and the NHS managerial culture. A more qualitative and interpretive approach towards exploring these issues has however become increasingly more popular especially over the last two decades (Mackenzie, 1995; Clarke & Yarrow, 1997; Young 1999; Bolton, 2003; Sambrook, 2006; Granter & Hyde, 2010; Mannion et al., 2010 and Jacobs et al., 2013). Whilst some of these studies, such as those reported by Blau (1963), Mackenzie (1995), Mellett & Marriott (1995), Clarke & Yarrow (1997), Young (1999), Merali, (2005), Exworthy et al., (2009), Granter & Hyde (2010), Mannion et al., (2010) and Jacobs et al., (2013) have provided a valuable insight into recognising that that public sector staff and more specifically NHS staff show a commitment to holding altruistic based values, a closer examination of these studies demonstrates that they have tended to neglect any explicit examination of the relative “strength” of this commitment. A deeper examination of these studies reveals interesting insights into these issues.

Whilst one of the findings from Blau’s (1963) widely cited study is that public sector workers hold altruistic based values, a closer investigation of his study provides an interesting and yet often neglected background context from which to understand this finding. Although Blau’s (ibid.) study primarily aimed to examine the interpersonal relations that developed between two USA based public sector organisations and the extent to which these relations influenced the nature of bureaucratic operations, an associated finding from this study was broadly interpreted to demonstrate

that public sector workers held altruistic based values. This associated finding was inferred through asking the public sector servants involved in the study the question “when do you get a special kick out of your job?” (ibid., p. 83). It could be argued that whilst the answers to this question provided by the USA based public sector staff could be broadly interpreted to demonstrate a commitment to altruistic based motives, it does not directly allow for an understanding of the relative strength of the public sector workers’ commitment to holding these values. So for instance it is not clear whether the public sector workers interviewed in this study developed altruistic based values because in the course of their employment they derived satisfaction from helping members of the public or whether they had an inherent commitment to altruistic based values which influenced them to the extent that they had actively sought to work in an altruistic based environment. An understanding of the relative strength of the public sector workers’ intrinsic commitment towards holding altruistic based values would provide an insight into the extent to which they afforded priority to their responsibility towards working in a socially responsible manner. For instance if the staff had reported that they had actively sought to work in an altruistic based environment because these values fitted with their personal ethos then it could be argued that these staff were more likely to demonstrate a stronger commitment towards upholding these values and working in a socially responsible manner.

Similarly, Boyne (2002) undertook a useful review of 34 empirical studies examining the differences between managers working in the public and private sectors and concluded that although these studies demonstrated that public sector managers held a greater commitment to serving the public compared to their private sector counterparts, there appeared to be a lack of

any empirical based research studies examining the relative strength of this commitment held by the public sector managers.

Likewise in Mellett & Marriott's study (1995), the extent to which NHS staff demonstrated a commitment and dedication to patient care was not the central focus of their study, instead this aspect was explored indirectly within the overall aim of that study which was to explore the extent to which economic considerations influenced the overall NHS agenda. The findings of Mellett & Marriott's study (ibid.) that the majority of NHS staff demonstrated a dedication to patient care was determined primarily through quantitatively analysed data resulting from the return of 203 completed questionnaires in which NHS workers were asked to rank five statements in terms of their extent of agreement with each. The assumption of staff commitment and dedication to patient care was made based on the responses to one of the five statements referred to the extent to which staff believed "they wanted to give the best service to patients" (Mellett & Marriott, 1995, p. 10).

Similarly the findings from Mackenzie's (1995) study, which drew upon a combined qualitative and quantitative based methodology to survey the NHS Organisation Culture, reported that "staff showed loyalty to the organization and to their clients (and that) the majority of respondents felt they provided high quality care..." (ibid., p. 71). It is however worth noting that this issue was one of a number of aspects under investigation within the study rather than of central importance to the study aims. Furthermore, the generalisability of these findings is limited since this study was restricted to staff working within a single NHS Trust. Likewise although a

study reported by the author previously (Merali, 2005)<sup>28</sup> demonstrated that the majority of the NHS managers who participated in that study held a commitment to altruistic based values, the study did not explore the relative strength of the managers' commitment to these values. In a similar vein although the commitment shown by clinical and non-clinical staff towards altruistic based values was inferred from qualitative based interviews in the studies reported by Clarke & Yarrow (1997), Exworthy et al. (2009), Granter & Hyde (2010), Mannion et al. (2010) and Jacobs et al. (2013), the strength of the commitment shown by staff to these altruistic values appears not to have been explicitly explored in these studies. Furthermore whilst a study by Young (1999) also demonstrated that managerial staff held altruistic based values, her study was limited in scope since it comprised interviews with only a small sample of five managers who all had nursing backgrounds and worked within one NHS Trust. It could be argued that it is not unsurprising that these managers were likely to report holding altruistic based values given their original clinical based vocation and training.

Very few studies have attempted to directly investigate the relative strength of the NHS managers' commitment to altruistic based values. A previously reported qualitative based separate study by the author (Merali, 2006)<sup>29</sup> had attempted to address this issue by asking the NHS managers their reasons for choosing to work in the NHS. Although this study provided some indication of the strength of the NHS managers' commitment to altruistic based values it was relatively limited in scope and sample size.

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<sup>28</sup> This previously reported separate study by the author will be referred to in this thesis as the author's earlier study reported in 2005.

<sup>29</sup> This was another separate study conducted by the author previously and will be referred to in this thesis as the author's earlier reported study in 2006.



Therefore although the findings from these various studies provide a valuable contribution in relation to demonstrating that NHS staff (including NHS managers) demonstrate a commitment to altruistic based values, the relative strength of this inherent commitment appears not to have been explored in any great depth. Overall the considerations above demonstrate a relative lacunae in research studies that have explicitly explored, from a predominantly qualitative and interpretive approach, the relative strength of the NHS managers commitment to altruistic based values. An understanding of this should help develop insights into the extent to which the NHS managers' have an inherent commitment towards working in a socially responsible manner. In line with the first objective of this study, this study therefore seeks to contribute towards addressing this relative gap in knowledge by seeking to "identify and explore the NHS managers' perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner".

A detailed discussion of the NHS managers' perceived core values and the extent to which these relate towards a commitment to working in a socially responsible manner in the context of the findings of this study is provided in chapter 5. The next section provides a literature review relating to the concept of New Institutional Theory which underpins the second objective driving this study.

### **3.3 New Institutional Theory**

#### **3.3.1 Introduction**

The second objective of this study<sup>30</sup> is to “explore the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”. An understanding of the managers’ views and beliefs of their public image should provide an insight into the NHS managerial culture since as explained by Smith (2000, p.153) the "conventional view of (organisation) culture centres on notions of shared values and beliefs". Furthermore it would be helpful to explore the extent to which the NHS managers’ views and beliefs of their public image impacts on their psyche and their overall commitment and contribution to the NHS.

New Institutional Theory is drawn upon in this chapter to provide a valuable background theoretical framework from which to understand the significance and relevance of exploring the NHS managers’ perceived public image and the implications and impact, if any, this might have on the managers’ psyche and their overall commitment and contribution to the NHS. However a clearer understanding of “New” Institutional Theory may be better achieved through distinguishing it from “Old” Institutional Theory. This is outlined in the next section where their respective contributions to the development of Organisation Theory have also been highlighted.

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<sup>30</sup> As stated in section 1.3.

### **3.3.2 Distinguishing between “Old” & “New” Institutional Theory**

The early Classical perspective (Hatch, 1997) essentially regarded organisations to be “closed” systems and consequently this perspective focused primarily upon examining the internal processes and operations of organisations in terms of enhancing organisational effectiveness, efficiency and performance. Institutional Theory in contrast “emphasizes that organizations are open systems – strongly influenced by their environments...” (Scott, 2003, p. 119). This approach is based on the view that organisations interact with and are influenced by aspects related to their external environment. The organisation’s environment is therefore also recognised to play a significant role in influencing the organisation’s development, adaptation and effectiveness. Philip Selznick (1957) along with March & Simon (1958) are regarded as the early proponents of Institutional Theory who were primarily concerned with exploring and understanding issues relating to organisational change and adaptation.

Old Institutional Theory focused mainly upon understanding organisational adaptation and change in relation to the internal aspects of the organisation such as the influence of leaders, managerial activity, organisational cliques and the politics of decision making (Selznick, 1957; March & Simon, 1958, Cyert & March, 1963). On the other hand “Neo” or “New” Institutional Theory which evolved as a result of the ideas developed by Hannan & Freeman (1977) and DiMaggio & Powell (1983) amongst others is based on the premise that organisations respond to macro environmental pressures that influence them to adapt and conform to environmental demands in order to acquire social legitimacy (Scott, 2003). Social legitimacy is viewed by Hatch (1997) to be the recognition, credibility and acceptance awarded to the organisation by the environment or society in

which it operates. This is seen to be significant since “organizations whose environments question their right to survive can be driven out of business” (Hatch, 1997, p. 85). In this context “social legitimacy” is therefore regarded to be a key resource upon which the organisation depends for its survival along with other essential resources such as raw materials, labour, capital and equipment (Hatch, 1997). Therefore whilst “Old” Institutionalism focuses mainly upon the internal organisational dynamics that act as catalysts and triggers for organisational change and development, “New” Institutional Theory focuses primarily upon an examination of the macro environmental forces which influence organisations to change and conform to environmental demands in their quest for social legitimacy (DiMaggio & Powell, 1983). The following section provides a more detailed explanation of “New” Institutional Theory along with outlining its relevance to the context of the study reported in this thesis.

### **3.3.3 New Institutional Theory: Its Relevance & Significance to this Study**

As mentioned in the previous section, “New” Institutional Theory provides a valuable contribution towards understanding the macro environmental pressures which influence organisations to adapt and conform to their environmental demands in their quest for social legitimacy. Furthermore as Thompson & McHugh (1995) highlight “the emphasis is on normative adaptation and the cultural rules to which organisations conform” (p.94-95). These externally determined normative and cultural rules influence organisations to adapt to and conform to their environmental demands. Scott (2003, p. 120-121) reinforces the significance of environmental pressures on organisations when he articulates “socially constructed belief

and rule systems exercise enormous control over organizations – both how these are structured and how they carry out their work”. Consequently whilst organisations adapt and conform to their environmental pressures through adopting structures and processes that grant them social legitimacy, they consequently become more homogenous in their field or industry. As starkly articulated by Hirsch & Lounsbury (1997, p. 80) “organizations that become more homogenous are legitimate and obtain resource support from their environment...organization death is the alternative”.

This process of organisational homogenisation is termed as “isomorphism” and is explained by Hawley (1968) to be a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions. In their seminal paper, DiMaggio & Powell (1983) have identified three such key forces namely “coercive”, “mimetic” and normative” isomorphism that impact upon and influence organisations to adapt and conform to their environmental demands. They explain “coercive isomorphism” to be pressures for change stemming from public sector government enforced regulations such as the need for organisations to conform to environmental regulations. “Mimetic isomorphism” is explained as pressures forcing organisations to mimic and model their structures and processes based on similar successful organisations in order to deal with environmental uncertainty and seek social legitimacy. Finally “normative isomorphism” is defined to be pressures that stem from the normative rules and values governing various professional bodies. Although organisations, depending on their functions, are likely to employ various different types of professionals (for e.g. managers working in different organisations also often belong to the same professional bodies

such as the Chartered Management Institute (CMI), Chartered Institute of Personnel and Development (CIPD), Association of Chartered Certified Accountants (ACCA), etc.), these professionals tend to be influenced by the norms and values of their professional bodies and are therefore likely to behave in line with these professional values and norms irrespective of the organisation in which they are employed.

New Institutional Theory therefore provides a valuable contribution in understanding the macro environmental pressures which influence organisations to adapt to and conform to their environment in order to achieve social legitimacy. Furthermore since organisations are essentially composed of organisational actors it could be argued that environmental expectations are a strong influence upon the way in which members of organisations behave and function in order to conform to society's expectations and achieve social legitimacy (Meyer & Rowan, 1991; Thomson & McHugh, 1995). The behaviour of organisations and its actors is therefore to a large extent influenced by the expectation of their environment (Meyer & Rowan, 1991) and the value of examining this area has been particularly propounded by prominent writers in this field such as Hirsch and Lounsbury (1997) and Weick (1969) who believe that once the perceptions of organisational members are affected, actions consistent with these perceptions will become evident. Addressing the question of the managers' perception of society's expectations of their role is relevant to this literature as there is the view that professional groups consciously or unconsciously behave in a manner in which they have come to be expected to in order to "increase their legitimacy and their survival prospects" (Meyer & Rowan, 1991, p. 41). Furthermore Deephouse (1996) views "public opinion" to be a key barometer in reflecting society's expectations

when he writes "public opinion ... has the important role of setting and maintaining standards of acceptability (within professional groups)" (1996, p. 1025). Therefore in the broader context of New Institutional Theory, the second objective of this study is to “explore the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”.

The next section reviews the literature in relation to the NHS managers’ perceptions of their public image and the impact of this upon the managers’ psyche and overall commitment and contribution to the NHS.

### **3.3.4 NHS Managers’ Views of their Public Image**

This section begins with an overview of the development of the NHS managerial role so as to provide the necessary background context to understand the public’s image of NHS managers. This is followed by an examination of the literature related to the NHS managers’ perceptions of their public views and the implications arising therein.

As explained in Chapter 2<sup>31</sup>, the Griffiths Report (DHSS, 1983) in the early 1980s reviewed the process of management and decision making in the NHS and subsequently led to the introduction of large numbers of a new powerful cadre of line managers throughout the NHS charged with the responsibility of implementing government policies and targets designed to make the NHS even more efficient, effective, accountable and business-like (Baggott, 1997; Ham, 1997).

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<sup>31</sup> See sections 2.2.1.1.2 & 2.2.2 for more details on the introduction of management functions within the NHS.

Today there are approximately 37,200 managers working in the NHS and whilst NHS managers are a relatively small proportion of the total NHS workforce (i.e. they represent only around 2.7% of the total workers employed by the NHS (NHS Confederation, 2013)) there has been an increase of 69% in the number of managers in the NHS in an eight year period since 1995 compared to 30% in the recruitment of doctors and 22% in nurses in the same period (NHS workforce census, 2003). The significant increase in managers has however been justified by the NHS on the basis that it is building management capacity from a historically low base (ibid.).

Whilst NHS managers, as the main change agents, have been charged with the responsibility of administering and implementing various government led reforms designed to make the NHS more efficient, effective, accountable and business-like they have been subjected to extensive, unceasing and widely publicised manager-bashing over the last few decades which has contributed towards shaping their commonly held negative public image (Warden, 1995). This “manager-bashing” has primarily been undertaken by politicians who for political expediency often regard NHS managers as convenient scapegoats for the lack of success of many of the government based reforms (Warden, 1995; Flanagan, 1997; Ham, 1997). For instance NHS managers have often been branded by politicians as the increasing army of “men in grey suits” responsible for draining the NHS of much needed resources (Ham, 1997). Furthermore the recent publication of the heavily publicised Francis Report (2013) which points the finger of blame for the Mid-Staffordshire scandal primarily at managerial inadequacies has further fuelled the public’s negative view of NHS managers.



Clinicians too have regularly and publicly attacked NHS managers for limiting their professional authority through their zealous efforts to cut costs in order to achieve government led targets often without demonstrating adequate concern for patient welfare (Atun, 2003; Davies & Harrison, 2003; Hawkes, 2007; Ilett, 2011). Brown et al.'s study (1994) also found that "clinicians gave the opinion that the priority of most managers is not the welfare of the patients..." (p. 67). In fact a highly respected and renowned hospital consultant went further in his criticism when he was relatively recently quoted in the national press as depicting NHS management to be a "cancer in the health service (which) is killing the lifeblood of our NHS" (Daily Mail, 2011).

Although it is recognised that NHS managers are motivated by a desire to improve patient care (Granter & Hyde, 2010), the widely reported attacks on the NHS managers in the national and local media continue to fuel the managers' negative public image. Furthermore a relatively recent public survey involving 2000 members of the public reported that 69% of the sample survey identified NHS management to be the service that the public would most like to axe (Local Government Chronicle, 2010). Previous research in this area has also substantiated the public's negative view of NHS managers through reporting that the public have a "clear lack of sympathy for NHS managers" (Learmonth, 1997: pg. 215). Learmonth (ibid.) further argued that it appeared unlikely that NHS managers would ever be popular with the public because NHS managers are thought to share an ideology about the nature of the NHS and the role of management within the NHS which is at odds with that of most members of the public. He concluded "it could be that there is a commonly held view by members of the public that a service which managers are trying to make ever more

efficient, rational and controlled cannot at the same time be caring and people centred" (ibid, p. 219). Despite some overt isolated actions by managers in support of public opinion against unpopular government reforms such as the Private Finance Initiative (Ruane, 2000), the NHS managers appear to continue to lack public support.

In relation to the NHS managers' perceptions of their public image, many studies have concluded that managers are very aware of their largely negative public image (Preston & Loan-Clarke, 2000; Ilett, 2011). Learmonth (1997, p. 214) quotes from a reported interview with a NHS chief executive who said "people used to think we did an admirable if rather humdrum job...now they think we're all fat cats, that we drive around in BMWs, behave like the guy in Cardiac Arrest and that we just don't care". In his study Learmonth attributed the principle cause for the low public esteem of NHS managers to the popular public view point that the traditional core values of the NHS are being violated by the efficiency seeking, cost cutting ethos of neo-Taylorist managers (ibid.). Another factor compounding the negative public image of NHS managers may be attributed to the intrinsic nature of the NHS managers' role when dealing with the public. For instance some of the government initiatives such as the "Patient's Charter" (Dept. of Health, 1992) and "Service First" (Cabinet Office, 1998) have placed managers in a prominent position within the NHS in terms of maintaining centrally determined government targets and standards. As a result of this managers often interact with patients only when complaints arise and this further serves to reinforce the public's negative view of NHS managers. The regular portrayal in the popular media of managers slavishly striving to meet Whitehall devised hospital targets has also contributed to strengthening the managers' negative public

image. Finally the negative public perception of NHS managers is further fuelled by the regular anti-NHS sentiments expressed by politicians who have regarded NHS managers as convenient scapegoats for the lack of success of some of the government led reforms (Warden, 1995; Flanagan, 1997; Ham, 1997, Ilett, 2011).

Although it is widely accepted that NHS managers are very aware of their largely negative public image (Learmonth ,1997; Preston & Loan-Clarke, 2000; Bolton, 2003; Ilett, 2011), the issue related to the extent to which the NHS managers' negative public image appears to have directly affected them remains relatively scantily researched. For example Learmonth's study (1997) provided a valuable insight into highlighting the NHS managers' negative public image based on a survey administered to 124 members of the public but the remit of his primary research did not extend to NHS managers themselves. He did not attempt to explore the effects of the negative public image on the NHS managers' psyche and overall commitment and contribution to the NHS. Issues connected to the negative public image of NHS managers have tended to be only explored indirectly in many of the studies undertaken in this area. Often studies in this area have been preoccupied with exploring the impact of the negative public image upon those NHS managers with a clinical background and explored how they make sense of their managerial identity as they reconcile their clinical role with their managerial cost-cutting and efficiency seeking functions (Bolton, 2003; Kirpal, 2004; Sambrook, 2006). For example Bolton's study (2003) focused upon examining the experiences of nurses as managers in the NHS and concluded that whilst nurse managers are generally aware of the negative public image associated with NHS managers, successful nurse managers have demonstrated the ability to

adapt to their multiple roles. Although Bolton's study (*ibid.*) provides a valuable insight into the awareness by NHS nurse managers of their negative public image and of the challenges they experienced in managing their multiple roles, this study was limited to only exploring the views of managers with a clinical background. A study reported by the author in 2009 also once again focused upon exploring the implications of the NHS managers' negative public image in connection only to those managers with a clinical background.

There are very few studies such as those reported by Preston & Loan-Clarke (2000) and the author previously in 2003 which have included NHS managers with a non-clinical background when exploring how they felt about their negative public image and the extent to which they experience any resultant challenges and tensions. Preston & Loan-Clarke's study (2000) was based on interviews with 39 NHS managers from clinical and non-clinical backgrounds and concluded that all the managers involved in that study were generally aware of their negative public image however this study did not explore the extent to which the managers dealt with any resultant challenges and tensions associated with their negative perceived public image. Similarly a study reported by the author previously in 2003 which was based on semi-structured interviews with 28 NHS managers with clinical and non-clinical backgrounds also reported that "despite the managers' opinion that the public perceives them to have an uncaring attitude, they themselves have not allowed this attitude to become institutionalised in their role" (Merali, 2003, p. 561). Once again however this study did not explore in any depth the extent to which the managers experienced any resultant personal or emotional tensions associated with this negative public image.

A general review of the literature in this area reveals a relative lacunae in existing research exploring in a direct and deep manner the extent to which the NHS managers (from both clinical and non-clinical backgrounds) experience any tensions and challenges in relation to their negative perceived public image. In line with second objective of this study, this study therefore seeks to contribute towards addressing this relative gap in the existing research by seeking to “explore the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”.

A detailed discussion of the NHS managers’ views of their public image and the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS in the context of the findings of this study is provided in chapter 6. The next section provides a literature review relating to self and work identity theory which underpins the third objective driving this study.

### **3.4 Self & Work Identity Theory**

#### **3.4.1 Introduction**

The third objectives of this study<sup>32</sup> is to “explore the healthcare managers’ self and work identities”. This is considered to be important since how managers perceive their self and work identities and how they are perceived by others has implications for their work performance, organisational commitment and satisfaction (Kirpal, 2004; Blenkinsopp & Stalker, 2004). Within this context the main literature relating to identity theory and more specifically Alvesson & Willmott’s (2002) theoretical

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<sup>32</sup> As outlined in section 1.3.

model has been reviewed in the following sections since this provides a valuable theoretical framework from which to understand and explore the healthcare managers self and work identities.

### **3.4.2 Understanding Individual Identity: Approaches & Theories**

The study of the concept of “individual identity” has become popular in a wide range of academic disciplines including Anthropology, Sociology, Psychology, Philosophy and relatively recently in Organisation Studies. As Linstead et al. (2009) explain, individual identity is concerned with the question “we all need to ask, and know, who am I? When we enter the world, the process of finding the answer is essential to our becoming fully developed individuals” (p. 448). Cerulo (1997) highlights the implications for understanding identity in relation to individual agency when she writes that seeking to answer the question “who am I” also has implications for understanding “how should I act?”. It could be argued that it is the quest to answer this rather philosophical question that makes the concept of “individual identity” of significance to, in fact, any discipline connected to the study of individuals in society. For example, as discussed later in greater depth, sociologists such as Henri Tajfel and John Turner have examined individual identity in the context of “Social Identity Theory” (Ashforth & Mael, 1989) which explores why individuals tend to be drawn to others (known as the “in-group”) who share similar characteristics based for instance on race, gender or class as opposed to others (the “out-group”) with different characteristics. On the other hand psychologists and the Psychoanalytic school (especially under the leadership of Sigmund Freud) have been preoccupied with exploring and understanding issues related to individual identity in the context of treating mental and emotional disorders in patients (Kenny et al., 2011). Organisation Studies has over the last

three decades also become increasingly interested in exploring individual identity given that “individuals (are) understood as social beings embedded in organizational contexts” (Alvesson et al., 2008 pp. 5-6). Fineman (1983) saliently highlights the increasing significance of the study of individual identity in Organisation Studies when he writes that the world of work has become regarded as the “defining aspects of personal status and identity” (p. 148). Furthermore Linstead et al. (2009) too support this viewpoint when they argue that as the world of work increases its significance to the lives of individuals in the 21<sup>st</sup> century this has an even more pronounced influence in shaping their individual self and work identities. The next section provides an outline of some of the various approaches to studying individual identity currently evident within Organisation Studies.

### **3.4.3 Theoretical Perspectives & Approaches to Understanding Individual Identity in Organisation Studies**

The increasing interest in the study of self and work identity within Organisation Studies has resulted in the adoption by organisation scholars of a diverse range of approaches and perspectives towards exploring issues related to individual identity. In this context Alvesson et al.’s seminal paper (2008) not only provides a valuable comprehensive overview of the broad range of theoretical perspectives and approaches related to exploring and understanding individual identity from an organisational perspective but also offers a unique and valuable meta-theoretical perspective towards conceptualising and understanding Identity Theory from the Functionalist, Interpretivist and Critical theoretical frameworks.

Whilst scholars adopting the Functionalist framework tend to explore, examine and understand individual identity with a predilection for

instrumental objectives of seeking to improve organisational efficiency and effectiveness, those developing an Interpretivist approach are more interested with studying and developing insights into issues related to how individuals construct and re-construct their identities and give meaning to this through their interaction with others. In this context individual identity is seen to be dynamic and emergent in nature (Watson, 1994). As Alvesson et al. (2008) highlight “for interpretively inclined organizational researchers, identity holds a vital key to understanding, the complex, unfolding and dynamic relationship between self, work and organization” (p. 9). On the other hand scholars favouring a critical approach tend to focus upon the study of individual identity in the context of exploring power relations within organisations and the wider society and their influences upon the construction and re-construction of individual identity. In this context the main spotlight upon understanding and examining the concept of individual identity is directed towards exploring issues related to individual control and resistance that stem from the complexity of power relations within organisations and within the wider society.

In this study the author has adopted a predominantly Interpretivist framework towards exploring and understanding the issues related to the healthcare managers’ self and work identities since this approach (which is in harmony with the ontological and epistemological position adopted in this study<sup>33</sup>) provides an appropriate framework to explore and develop insights into understanding how the healthcare managers construct and reconstruct their self and work identities and give meaning to this through their interactions with others.

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<sup>33</sup> See section 4.2.5 for a rationale supporting the methodological position adopted in this study.



Whilst Alvesson et al. (2008) provide a valuable meta-theoretical perspective towards conceptualising and understanding identity theory, Kenny et al. (2011) provide a valuable overview of some of the common approaches and theoretical perspectives adopted in the field of Organisation Studies towards understanding the concept of individual identity. These include Social Identity Theory, the Psychoanalytic approach, the Foucauldian perspective, the Symbolic Interactionist approach and the Narrative based approach as outlined in the following sections. It is however important to bear in mind that whilst these various approaches and perspectives are useful in developing insights into issues related to self and work identity, their respective limitations also need to be heeded.

#### **3.4.3.1 Social Identity Theory**

Social Identity Theory (SIT) which was developed within the field of Social Psychology is attributed to the work of Henri Tajfel amongst others. SIT focuses upon developing an understanding of social groups and their influences upon shaping individual identities since it is held that “social identity is usually more powerful than individual identity” (Anon, 2007, p. 30). Interestingly SIT also provides valuable insights into understanding individual identity based on how individuals identify or dis-identify with specific groups. Categories or classifications are derived from associations or dis-associations made between individuals and specific groups, known as in-groups or out-groups, based on for instance social class, gender, race or other physical and social characteristics. SIT highlights the extent to which individuals often generalise and or stereotype from their limited experiences when making associations with in-groups and dis-associations with out-groups.

A number of studies by organisation theorists including those by Hotho (2008), Korte (2007) and Hallier & Forbes (2005) have drawn upon SIT to develop useful insights into understanding the dynamics of organisational group membership in relation to a consideration of their influences upon individual norms, values and identity. For instance a recent study by Au and Marks (2012) draws upon SIT to develop interesting insights into the issues connected to the membership of virtual and culturally diverse international groups in relation to explaining the implications of this for effective organisational performance. Although many approaches that draw upon SIT tend to develop a relatively Functionalist perspective, they have generated valuable insights into understanding issues related to social groups and their influences upon shaping individual identities. On the other hand some of the limitations of the various approaches to understanding individual identity from a SIT perspective include a neglect of the consideration of more macro influences upon shaping individual and social group identities such as those related to dominant discourses as discussed later in the context of the Foucauldian perspective<sup>34</sup>.

#### **3.4.3.2 Psychoanalytic Approach**

Sigmund Freud who is regarded as the founder of the Psychoanalytic approach originally developed his work in order to understand individual identity in the context of treating mental and emotional disorders amongst patients presented within clinical psychology. This approach is built on the assumption that conscious human feelings, drives and behaviors are manifestations of the “unconscious” psyche. Psychoanalysts believe that efforts to understand the unconscious aspects of the individual psyche would unravel insights into understanding and addressing the conscious

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<sup>34</sup> As outlined in section 3.4.3.3.

irrational fears, anxieties and behaviours of patients presented for treatment. In a similar vein organisation theorists have drawn upon the Psychoanalytical approach to explore and understand “the underlying, unconscious causes of behavior” influencing individual identity (Willcocks & Rees, 1995, p. 32). Similarly Gabriel & Carr (2002) provide an interesting and comprehensive overview of the use of Psychoanalytic approaches to explore issues related to management and organisation. Other interesting studies also utilising the Psychoanalytic approach to develop an understanding of Organisational Behavior include those by Swarte (1998), Young (2000), and more recently a study by Macaux (2012) which explores issues related to effective organisational leadership.

Although the Psychoanalytic perspective develops a useful understanding of the unconscious human psyche and its influence upon shaping the individual’s consciousness and identity its limitations include a tendency for a predominant reliance upon subjective elements articulated by the individual rather than objective based empirical data which can be verified scientifically. Furthermore the Psychoanalytic approach is also accused of being overly occupied with micro issues of significance for the individual rather than more macro aspects such as the influence of dominant discourses within society which may influence and/or shape the individual’s identity as discussed in the next section.

#### **3.4.3.3 Foucauldian Perspective**

The Foucauldian perspective is based upon the work of Michel Foucault connected to power, knowledge and dominant discourses. This critical based perspective highlights the interplay of more macro issues in influencing and shaping individual identities. Whilst SIT and the

Psychoanalytic approach regard the individual to be central to a large extent in shaping his/her identity, the Foucauldian perspective de-centres the individual and focuses more upon macro aspects such as the influence of social structures and dominant discourses upon the construction and reconstruction of individual identity. As Kenny et al. (2011) succinctly explain “a Foucauldian perspective on identity conceives of subjects coming to occupy certain subject positions (ways of understanding themselves) within, and/or becoming positioned by, discourses that enable and constrain us by structuring our sense of self and our relationship to the world” (p. 20). Individual identity is therefore seen to be essentially subject to the dominant discourses prevailing in society which shape and regulate the normalisation of behavior (Hatch & Cunliffe, 2006). This view is further developed by Postmodernists and Post-structuralists in their quest to understand the dynamics of self surveillance in contemporary society and organisations whereby individuals appear to self-discipline themselves so as to behave in the manner warranted by society and organisations (Barratt, 2002). The Foucauldian perspective is particularly popular with critical theorists who have drawn upon it to understand and explore a number of organisational issues including those related to human resource management (Barratt, 2002); human resource development (Trehan, 2004); resistance in organisations (Dalglish, 2009) and more recently management development training (Andersson, 2012). Although the Foucauldian perspective is valuable in highlighting the macro influences involved in shaping individual identities its limitations include the relative sidelining of the significance attributed to the extent of autonomy exercised by the individual in shaping his/her individual identity.

#### **3.4.3.4 Symbolic Interactionist Approach**

The Symbolic Interactionist approach draws upon the social constructionist perspective in understanding and exploring individual identity (Kenny et al., 2011). It builds upon the work of George Mead and Erving Goffman in relation to how individuals construct and re-construct their identities through sense making. Mead held that an individual's identity in terms of "who am I" is largely influenced by their social interaction with others in the context of accepted societal norms and values (Hatch & Cunliffe, 2006; Kenny et al., 2011). So for example in pre-modern times a man was expected to be the hunter and provider for his family and so the identity of a boy as he grew up is framed by his interaction with others around him who in turn influence his sense of self through expecting him to grow up to behave in the traditional strong and masculine manner befitting a hunter. Whilst Mead therefore believed that the individual's identity and sense of self manifested itself in terms of reflecting society's expectations, Goffman on the other hand developed a more critical approach to understanding individual identity (Kenny et al., 2011). He ascribed to the dramaturgical perspective and believed that individuals were able to behave in manipulative ways such that they were able to adopt a wide range of roles as if they were on a stage when behaving in different contexts. So whilst in the previous example the boy may behave in a masculine, aggressive and strong manner when amongst his peers, he was also capable of adopting a more sensitive and caring, nurturing role in private at home if and when needed. Hence the individual's identity as to "who am I?" is controlled and staged depending on the changing contextual situation.

The Symbolic Interactionist perspective has also been drawn upon in management and organisation studies in so far as management "behaviours

(are regarded to) emerge from the meaning managers attribute to the constituents and contingencies in their social environment... (and) meaning is viewed to result from the social interactions and symbolic, interpretative process(es)” (Sashittal & Jassawalla, 1998 p. 533). A wide range of studies in the management and organisation field have drawn upon the Symbolic Interactionist perspective to explore and understand issues of identity including those by Sashittal and Jassawalla (1998) related to management identity and Volpe & Murphy (2011) with regards to the identity of married professional women. Whilst the Symbolic Interactionist approach provides a unique and useful lens to develop insights into understanding and exploring individual identity, its limitations are similar to those of the SIT and the Psychoanalytical approach in that it appears to neglect the consideration of the more wider macro issues such as for example the influence of dominant discourses upon shaping individual identities.

#### **3.4.3.5 Narrative Based Approaches**

The Narrative based approaches are underpinned by an interpretive perspective in terms of understanding how individuals make sense and derive meanings from their actions. These approaches involve the process of individuals providing narrative accounts of specific events or issues through for example telling stories, giving interviews, writing diary reflections or engaging in creative performances (Kenny et al., 2011). This approach has been drawn upon to explore issues and events in a wide range of social disciplines such as Anthropology, Sociology, Psychology and Philosophy. Management and organisation theorists have also drawn upon narrative based approaches to explore and develop insights into individual identity in a range of contexts such as those related to social entrepreneurial identity (Jones et al., 2008), organisational learning (Lamsa & Sintonen,

2006) and career counselling (Gibson, 2004). These narratives based approaches to examining issues related to identity are found to be valuable since as explained by Gibson (2004) “they capture events and experiences in a way that enables us to examine reflectively what we are doing and who we are becoming” (p. 178). Whilst this approach is found to be particularly valuable in the context of adopting a social constructionist approach to understanding and making sense of individual identities (Jones et al., 2008), its limitation includes taking subjective and often overly imaginative or selective accounts offered by the participants at face value which may not necessarily represent accurate and factual holistic representations of the events or issues. As concisely articulated by Jones et al. (2008) “human agency and imagination determine how a story is told, what events are included and excluded, how events are plotted, and what meanings are ascribed to them” (p. 334).

Whilst the broad range of approaches and perspectives outlined so far help to provide distinctive and rich insights into exploring and understanding issues related to self and work identity, an awareness of their ontological underpinnings assists in understanding why certain approaches are favoured by particular organisational scholars. So for example whilst SIT is often drawn upon by those scholars inclined to a Functionalist viewpoint in order to understand issues related to social groups and their influences upon shaping individual identities so as to improve organisational efficiency and effectiveness, the Symbolic Interactionist and Narrative based approaches tend to be favoured by scholars leaning towards an Interpretive framework in understanding how individuals construct and re-construct their identities and give meaning to this through their interaction with others. On the other hand the Foucauldian perspective tends to be popular with critical scholars

interested in exploring issues connected to the relations between power and control within organisations and the wider society through for example exploring the nature of dominant discourses and their influences upon the shaping and re-shaping of individual identities.

With regards to this study the author has adopted a predominantly Interpretivist approach towards exploring and understanding the issues related to the healthcare managers' self and work identities. This approach which is in harmony with the ontological and epistemological position adopted in this study<sup>35</sup> provides an appropriate framework to explore and develop insights into understanding how the healthcare managers construct and reconstruct their self and work identities and give meaning to this through their interactions with others.

Whilst the preceding section has outlined some of the main theoretical approaches and perspectives to understanding self and work identity that are prevalent in Organisation Studies, the next section provides a more detailed overview of the various theoretical approaches useful in exploring and understanding self and work identity and the interrelationship between them.

#### **3.4.4 Theoretical Approaches to Exploring & Understanding Self-Identity**

##### **3.4.4.1 Self-Identity**

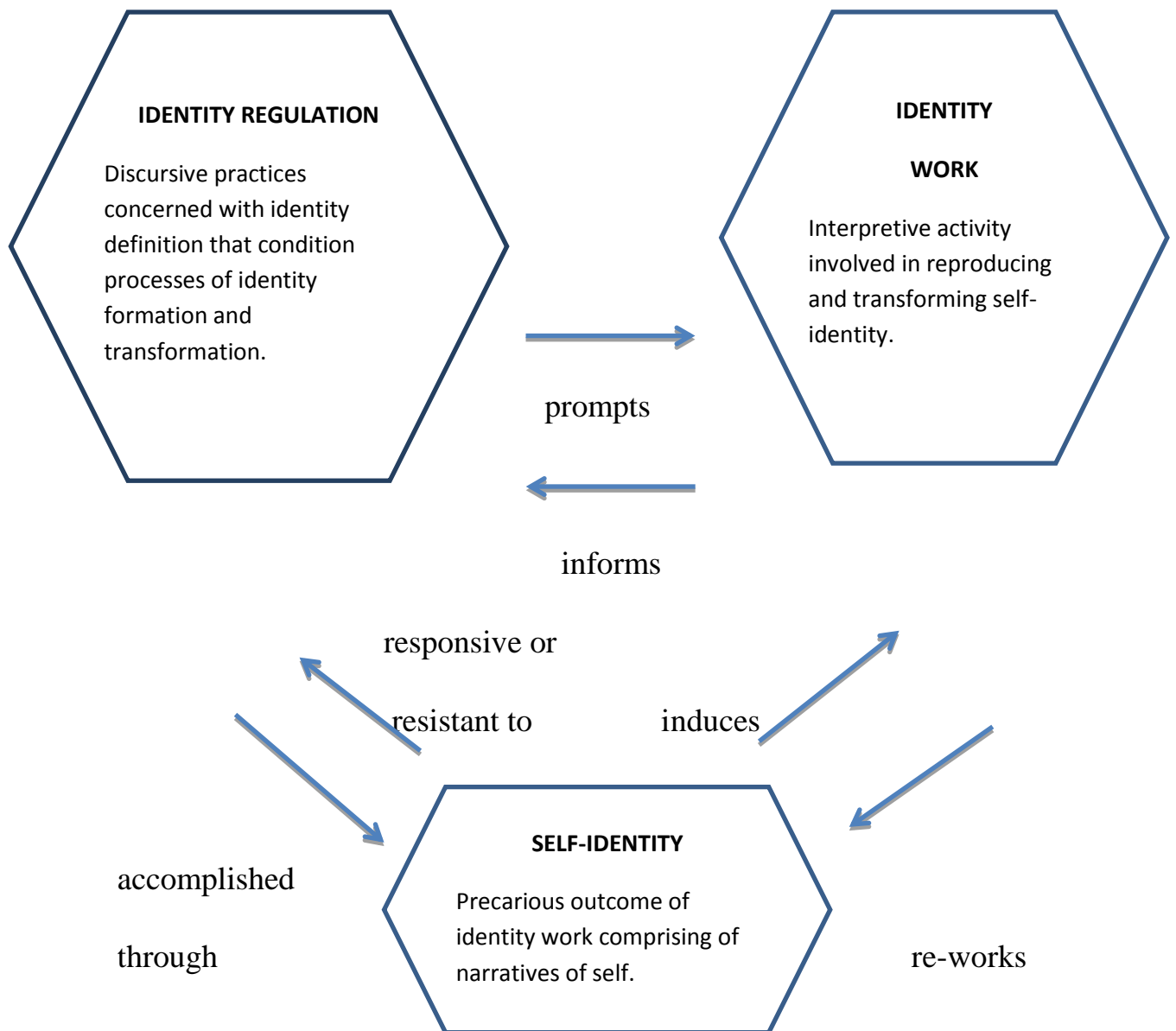
Self-identity is seen by Alvesson & Willmott (2002) to reflect the core essence of the individual's identity in terms of addressing the question "who am I?". They contend that the individual's "self-identity is assembled out of cultural raw materials...that are derived from countless numbers of

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<sup>35</sup> See section 4.2.5 for a rationale supporting the methodological position adopted in this study.



interactions with others and exposures to messages produced and distributed by agencies (schools, mass media) as well as early life experiences and unconscious processes” (p. 626). As shown in Figure 5, Alvesson & Willmott (2002, pg. 627) provide a valuable theoretical model to help analyse and explore the dynamics involved in the (re)creation of individual identity in relation to three key factors namely “identity regulation”, “identity work” and “self-identity” and in understanding the complex interrelationship between them. Whilst the main focus in Alvesson & Willmott’s paper (2002) is to draw upon their model to examine issues related to organisational control, the model also provides a useful background framework from which to identify and understand the interrelationship between these three key factors in the (re)formation of individual identity within the context of the workplace.



**Figure 5: Identity Regulation, Identity Work and Self-Identity**  
(Alvesson & Willmott, 2002, p. 627)

As shown in Figure 5 the factors influencing the formation and transformation of “self-identity” is highly complex since as succinctly put by McKenna (2010) “identity construction is not undertaken in a vacuum...rather it is undertaken dialogically, in context with other people, within organizations and in society” (p. 6). This complexity is further

compounded by the dynamic and emergent nature of the framework whereby the formation and transformation of self-identity is regarded as a “continuous process through which we come to terms with our changing world through a process of shaping ourselves” (Watson, 2003, pg. 59). Furthermore not only is an individual’s identity dynamic and emergent but it can also be viewed more holistically as representative of multiple identities. Alvesson et al. (2008) make this point lucidly when they write “defining ourselves as secretaries, middle managers, or professors, for instance, does not entail simply stepping into pre-packaged selves, but always involves negotiating intersections with other simultaneously held identities (e.g. a black male professor and parent) and making individualized meaning in interaction with the people and systems around us (e.g. a competent, high-status secretary)” (p. 10). Therefore self-identity as also advocated by Knights & Willmott (2012, p. 106) “can be thought of as the means by which we see ourselves in a more holistic way”.

The complexity of this process is even further compounded by the fact that identity formation is not a product only of interactions between the person and other individuals but “identity is formed in response to what a person might be expected to be defined by the structures, context and discourses within which they operate (McKenna, 2010, p. 6). So the dominant structures and discourses prevalent within organisations and the broader society, which constitute “identity regulation” as explained in the following section are also recognised to play a significant part in influencing the formation and transformation of an individual’s self-identity.

#### **3.4.4.2 Identity Regulation**

As explained by Alvesson & Willmott (2002, p. 625) “identity regulation encompasses the more or less intentional effects of social practices upon processes of identity construction and reconstruction (such as) induction, training and promotion procedures are developed in ways that have implications for the shaping and direction of (individual) identity”. Identity regulation can therefore be regarded to be the fundamental influences outside the individual such as the discursive practices dominant in managerial discourses that shape and re-shape individual identities. For example it could be argued that the majority of managers working in heavy industry in the west during the Fordist times would have been subjected to the managerial discourses prevalent at the time which tended to predominantly favour an autocratic managerial approach. It is therefore likely that this style of management would most likely have influenced a manager’s sense of “who they are” and by implication their behavior with subordinates in the workplace. Identity regulation is deemed to prompt and influence “identity work” as discussed in the next section

#### **3.4.4.3 Identity Work**

Alvesson et al. (2008, p. 15) explain identity work to be “the ongoing mental activity that an individual undertakes in constructing and understanding of self that is coherent, distinct and positively valued”. Hence identity work can be regarded as the key sense making interpretive process undertaken by the individual which is influenced by identity regulation. The process of identity work undertaken by the individual therefore plays a key influencing factor in the formation and reformation of the self-identity of the individual.

Whilst self-identity as has been explained so far is seen to be the outcome of identity work which is prompted by identity regulation, it is important to emphasise that the relationship between the three factors (i.e. self-identity, identity regulation and identity work) should not be assumed to be only linear but rather the process of the construction and reconstruction of the individual's self-identity is conceived by Alvesson & Willmott (2002) to be a two-way interrelationship between the various factors as illustrated in Figure 5. So whilst the process of the construction and reconstruction of the individual's self-identity is influenced by identity work, individuals within an organisation as indicated by Alvesson & Willmott (2002, p. 621) "are not reducible to passive consumers of managerially designed and designated identities". Hence as shown in Figure 5, individuals may conform to some aspects of identity regulation but could actively or passively resist other aspects thereby challenging and redefining relevant aspects of identity regulation. The extent of this interrelationship between self-identity, identity regulation and identity work underscores the complexity involved in the formation and reformation of the individual's self-identity.

Furthermore understanding the concept of self-identity is deemed to be far from straightforward as it can be viewed to comprise and reflect multiple aspects of the self including one's work identity. According to Watson (2006) "work identity" can be regarded to form a part of the holistic self-identity of an individual. It is worth emphasizing that whilst work identity can be seen to be a part of the holistic self-identity of the individual it is increasingly regarded as a particularly important component of self-identity since as explained earlier in this chapter, Fineman (1983) and Linstead et al. (2009) emphasise that as the world of work increases its significance to

the lives of individuals in the 21<sup>st</sup> century this has an even more pronounced influence in shaping their individual self identities. It would be useful to examine the concept of work identity in further depth at this stage.

#### **3.4.4.4 Work Identity: Managerial & Professional Identity**

As explained in the previous section, work identity is regarded to comprise a particularly important component of the holistic self-identity of an individual especially given the increasing significance of the world of work to the lives of individuals in the 21<sup>st</sup> century. French et al. (2011) highlight this point further when they write “the notion of identity (who am I?) is intimately tied to the meaningfulness of one’s job” (ibid., p. 379). Work identity is defined by Walsh & Gordon (2008, p. 47) as “a work-based self-concept, constituted of a combination of organizational, occupational, and other identities that shapes the role a person adopts and the corresponding ways he or she behaves when performing his or her work”. A review of some of the literature relating to the (re)construction of self and work identity appears to generally show consensus on the complex factors that influence and impact upon the construction and reconstruction of the individual’s self and work identity (Watson & Harris, 1999; Watson, 2003; Alvesson & Willmott, 2002; McDonald, 2005). Kirpal highlights the complexity of the identity formation process when he states “it can be described as a complex process whereby societal influences and individual dispositions meet and generate an internal process that leads to the formation and manifestation of identities” (2004, pg. 277). An understanding of work identity is however not a straightforward process since it requires a consideration of the question “who am I?” in the context of the complexity associated with work organisations. For instance an individual’s identity is not regarded as fixed and stable but one which is

viewed to be in a state of an on-going dynamic process of formation and reformation such that the identity of a manager is regarded to be “emergent” in nature (Watson & Harris, 1999; Blenkinsopp & Stalker, 2004).

Furthermore whilst the individual’s work identity may be shaped by the nature of their employing organisation (e.g. working for a world renowned prestigious corporation or for an altruistic based organisation), this identity is also often shaped by their membership of other professional groups or organisations (e.g. being a manager and/or an accountant, a member of a trade union and/or a supervisor in charge of assessing/disciplining workers). Exploring and understanding an individual’s holistic work identity can therefore be a complex process given the individual’s unique and varying affiliations within and outside of the organisation that influence his/her work-identity. Whilst it is therefore not possible to examine every aspect of work-identity it is worth highlighting and distinguishing between “managerial identity” and “professional identity” given that these aspects are particularly pertinent to the study explored in this thesis.

McKenna (2010, p. 5) believes “managerial identity is partly a product of dominant discursive/ideological formation rather than individual choice...managers assume a managerial identity that reflects current dominant discourse about what a manager should be”. Therefore when defining “who am I?” from a managerial perspective, it appears that the prevailing dominant managerial discourses have a significant influential role in shaping the individual’s work identity. This therefore emphasises the point made by McKenna (*ibid.*, p. 6) that “the social construction of identities is subject to influences outside of the individual”.

Professional identity on the other hand relates to the consideration of the question “who am I?” from allegiances the individual may have with particular professional bodies such as accountancy, medicine and law (McAuley et al., 2007). As Kirkpatrick et al. (2005) articulate, members of a profession tend to be highly defensive in safeguarding and justifying their reputed and privileged positions. Individuals may therefore consider their work identities to be influenced by a wide range of affiliations within and outside of the employing organisation depending on the strength of their individual affiliations to various organisational and professional bodies.

The next section provides a review of the literature specifically related to the NHS managers’ self and work identity.

### **3.4.5 NHS Managers’ Self & Work Identity**

Over the last two decades there have been an increasing number of studies exploring the socially constructed realities and work experiences of NHS managers in order to specifically understand the implications of this for their work identities (Forbes & Prime, 1999, Hallam, 2002; Bolton, 2003; Kirpal, 2004; Sambrook, 2006; Wise, 2007; Ilett, 2011; Hyde et al., 2012). Acknowledging the increasing involvement of clinicians over the last three decades in healthcare management positions, a majority of the studies within the NHS related to managerial identity appear to have been mainly concerned with examining how clinical professionals such as doctors and nurses have adjusted to the transition from a clinical role to one that is predominantly or exclusively managerial as a result of career progression and/or personal development. For example some studies examining the role of nurses and nurse-managers have identified the role conflicts these groups of staff have experienced in relation to their work identities and



occupational roles as a result of their changing and challenging occupational and organisational roles (Hallam, 2002; Bolton, 2003; Kirpal, 2004; Wise, 2007). Research by Bolton (2003) which was based on nurse managers concluded that whilst nurse managers can successfully adopt multiple roles as caring professionals and entrepreneurial managers they experienced a degree of role conflict and contradiction within this hybrid role. In some cases the inadequate education, training and development provided to clinicians making the transition to management and even to NHS managers in general has also been highlighted in previous research (Newman et al., 1996; Flanagan, 1997). On the other hand other studies such as that by Forbes & Prime (1999) and Sambrook (2006) have reported cases where, with some exceptions, nurses and radiographers have adopted managerial roles without experiencing any difficulty in their emergent co-existing managerial and professional identities.

There however appear to be relatively few studies exploring in any depth the tensions and challenges experienced by NHS managers with non-clinical and clinical backgrounds related to their perceived public image and the consequent impact of this upon their self and work identities.

Amongst the studies that have touched upon this relatively unexplored field is the author's previous study reported in 2009 which sought to "identify and explore tensions and challenges experienced by NHS managers working for a socially responsible organization and the implications this had for the (re)formation of their work and self identities" (Merali, 2009, p. 152). Although this study provided useful insights into issues related to the self and work identities of the NHS managers in relation to their negative perceived public image, the study was restricted to exploring issues affecting only those managers who had a clinical background. On the other

hand Ilett's study (2011) delved into a wide range of issues related exclusively to the managerial identities and experiences of only "senior" NHS managers working in Scotland. This included examining the senior NHS managers' affiliation to the NHS along with exploring issues arising from their transition from working in a clinical role to a predominantly non-clinical managerial role and the effect of the negative media image on their managerial identities. The study conducted by Hyde et al. (2012) on the other hand generated useful insights into issues related to "how (NHS) middle managers defined their work identities and how their work identities were constructed around them with consequent implications for the organisation of work" (p. 8). The study by Hyde et al. (ibid.) identified tensions experienced by middle managers in relation to their work identity and reported that they appeared to be distancing themselves from their formal "middle management" identities mainly due to the widespread negative image associated with the role of middle management and management more generally and within the NHS. Whilst these various studies have generated insights into the wide range of issues related to the construction and re-construction of NHS managers' work identities, they are limited in the extent to which they have focused upon exploring explicitly and in an in-depth manner how NHS managers with non-clinical and clinical backgrounds view their public image and the implications, if any, this has for their self and work identities.

In line with the third objective of this study, this study therefore seeks to contribute to developing existing knowledge in this relatively under-researched field through investigating in an explicit manner how the healthcare managers view their public image so as to explore the implications of this for the healthcare managers' self and work identities.

A detailed discussion of the NHS managers' self and work identities in the context of the findings of this study is provided in chapter 7. The next section provides a literature review relating to the concept of Corporate Social Responsibility which underpins the final objective driving this study.

### **3.5 Corporate Social Responsibility (CSR)**

#### **3.5.1 Introduction**

The last objective of this study<sup>36</sup> is “to critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers”.

The concept of CSR appears to be gaining increasing momentum and popularity within the political, economic, social and corporate context of the twenty-first century as corporations globally, for a variety of reasons, adopt and implement strategies related to social responsibility. A key stimulus driving organisations around the world to adopt and implement CSR related strategies has been the realisation of its many associated benefits. These include an improved corporate public image, increased sales, better financial performance and the development of a more committed and dedicated work force (Jones & Comfort, 2005; Chen, 2011; Gupta, 2012).

Whilst the concept of CSR tends to be mainly discussed in the context of private sector organisations this does not imply that the principles of CSR are irrelevant to public sector organisations (including the UK NHS). In relation to public sector organisations the principles associated with

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<sup>36</sup> As stated in section 1.3.

CSR, as outlined in more detail later in this section, tend to be discussed in the context of more appropriate relevant concepts such as “ethics”, “social responsibility”, “public accountability” and “citizen orientation” amongst others. It is also widely accepted that the extent to which an organisation’s CSR strategy is successful is to a large extent contingent upon the commitment, contribution and support demonstrated by its staff towards this strategy (Hemingway & MacLagan, 2004; Collier & Esteban, 2007). Furthermore since organisations are recognised to positively influence the perceptions and commitment of their staff through their CSR strategies this in turn may explain why many organisations tend to often make an explicit reference to the commitment and contribution of their staff within their publicised CSR strategies (Rupp et al., 2006).

Interestingly whilst the public sector has tended to be regarded as a role model for the private sector in its approach to transparency and commitment to CSR (Michael & Gross, 2004) it has usually been the private corporations, as discussed later in this section, that appear for various reasons to be actively promoting their employees’ commitment to socially responsible behaviour within their publicised CSR strategies (Moir, 2001). It is however worth noting that although many studies have reported that public sector staff, including NHS managers, appear to hold an inherent commitment to altruistic based personal value and thereby demonstrate a strong commitment to behaving in a socially responsible manner (Blau, 1963; Mellett & Marriott, 1995; Mackenzie, 1995; Clarke & Yarrow, 1997; Young, 1999; Boyne, 2002; Mannion et al., 2010; Jacobs et al., 2013) there appears to be a relative absence of studies examining the extent to which this commitment is reflected in the CSR strategies adopted and publicised by public sector organisations. It is in this context that this

study seeks “to critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers”.

The next section begins by reviewing the main literature related to the concept of CSR and the extent to which it has been adopted by private and public sector organisations followed by a more specific review of the literature and research related to the extent to which private and public sector organisations reflect the commitment and contribution of their staff within their publicised CSR strategies.

### **3.5.2 Overview of CSR: Theoretical Viewpoints & Approaches**

As already mentioned in the preceding section the concept related to CSR appears to be gaining increasing momentum and popularity within the political, economic, social and corporate context of the twenty-first century. Testimony to this popularity is that a basic search of the key words “Corporate Social Responsibility” using “Google Scholar” returned about 1,920, 000 results<sup>37</sup> whilst a more focused search of this concept restricted to scholarly published papers reported in management related academic journals using the “Emerald Management eJournals” database returned 18,044 results<sup>38</sup>. Furthermore the increasing prominence and popularity of the concept of CSR in the corporate and academic domains is reflected in the constantly expanding range of publications within these fields. This is also evidenced in the emergence of a wide range of dedicated national and international specialist academic journals related to CSR which include the Social Responsibility Journal, Corporate Governance, Journal of Global Responsibility, Journal of Business Ethics, Corporate Social

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<sup>37</sup> Search results as reported on 26<sup>th</sup> Jan 2014.

<sup>38</sup> Search results as reported on 26<sup>th</sup> Jan 2014.

Responsibility & Environmental Management and the International Journal of Sustainable Strategic Management amongst others.

Interestingly despite the significant and expanding range of literature related to CSR in the public and academic domains there appears to be no clear consensus on its definition or application (Windsor, 2001; Joyner & Payne, 2002; Crowther & Raymon-Bacchus, 2004). For example the EU Commission's green paper adopts a broad approach towards CSR which is defined as "essentially a concept whereby companies decide voluntarily to contribute to a better society..." (Bergkamp, 2002) whilst the World Business Council for Sustainable Development is narrower in its definition and includes an explicit reference to the role of management within its approach to CSR which is defined as "the ethical behaviour of a company towards society....management acting responsibly in its relationships with other stakeholders who have a legitimate interest in the business..." (WBCSD, 1999). It is however worth emphasising that although the formal concept of CSR is often regarded to have evolved over the last five decades, the principles of CSR are not novel and have in fact been prevalent in organisational practice all over the world since the onset of the industrial revolution (Crowther & Rayman-Bacchus, 2004). It could therefore be argued that the emergence and development of the concept of CSR is to some extent an act of public acknowledgement and formalisation of the principles and practices of CSR (which have already been in existence since early days of industrialisation) as it gains increasing popularity in the mainstream practitioner and academic domains. Furthermore a number of other more specialised and associated concepts have also evolved over the last four decades such as Corporate Governance, Sustainability, Corporate Social Responsiveness, Corporate

Social Performance and Corporate Greening. Whilst these concepts can be considered to be allied directly or indirectly to the concept of CSR it is not in the scope of this study to provide a review of these wide ranging associated concepts.

It would be useful at this stage to provide an overview of the main theoretical viewpoints, approaches and perspectives related to the development of the concept of CSR. A wide range of relevant literature as discussed in the following sections have been consulted to provide this overview. In particular the comprehensive reviews of the evolution and development of the concept over the last five decades by Carroll (1999) and more recently by Lee (2008) have proved particularly valuable in this regard.

#### **3.5.2.1 CSR: Early Origins & the Shareholder Centred Viewpoint**

Bowen's (1953) text titled "Social Responsibilities of the Businessman" is often cited as sparking the debate on the view that organisations were not only accountable to shareholders for maximising shareholder value but were also responsible to the larger society for engaging in socially responsible behaviour due to moral and ethical reasons. This view that organisations should engage in socially responsible behaviour for the benefit of society due to moral or ethical reasons faced significant resistance from the supporters of the neo-classical school such as Milton Friedman (1962) who firmly believed that since businesses were in the main accountable to shareholders their sole obligation was therefore to maximise shareholder value. The neo-classicists therefore held that the engagement by corporations in CSR related activities placed an unfair, unreasonable and unacceptable cost burden upon the corporations' shareholders. They argued that the burden of responsibility for such

socially responsible behaviour rested not with corporations who were accountable only to shareholders but with governments and the wider society instead. This resulted in what appeared to be a clear and irreconcilable difference between those who advocated the adoption of CSR related activities by organisations and those who believed the adoption of CSR activities would inevitably lead to poor Corporate Financial Performance (CFP) due to the associated increased costs incurred by organisations for CSR related activities (Lee, 2008). This rift however was bridged to some extent by the development of the “enlightened organisational self-interest” viewpoint as outlined in the next section.

#### **3.5.2.2 CSR: The Enlightened Organisational Self-Interest Viewpoint**

Over time, as the CSR debate gained momentum, the efforts to reconcile the divisions between the neo-classical viewpoint and those who believed that organisations should adopt CSR related activities started paying dividends (Lee, 2008). By the 1970s it became evident that most stockholders did not just own stock and shares in one company but in order to spread their investments risks they tended to invest in a larger portfolio of companies. As a result they became increasingly aware of the long term implications of the effects of competitive pressures between organisations and the adverse consequences of individual organisational self-interest related practices for other organisations and the wider society. Furthermore as pressure mounted on organisations to behave in a more socially responsible manner they also recognised the benefits arising to them for engaging in CSR related activities. These benefits included an improved organisational reputation as far as the wider public was concerned which in turn resulted in enhanced customer and employee loyalty to the organisation (Moir, 2001). This “enlightened self-interest” of organisations



as far as their commitment towards behaving in a socially responsible manner was therefore not purely motivated for altruistic reasons but primarily driven by the recognition of the positive relationship between an organisation's CSR activities and its long term CFP (Lee, 2008).

#### **3.5.2.3 CSR: The Stakeholder Viewpoint**

The stakeholder viewpoint has gained increasing popularity in the literature related to CSR more recently (Carroll, 1996; Steiner & Steiner, 2000; Lee, 2008). The stakeholder approach to CSR is premised on the view that since organisations operate within society, their practices directly or indirectly affect a broad range of stakeholders who apart from shareholders include employees, suppliers, customers and the general public. According to the stakeholder viewpoint, organisations should therefore exercise responsibility and be accountable to a wider group of stakeholders that are interested and/or affected by their activities. Once again this viewpoint has been accompanied by the recognition of the positive interrelationship between the organisation's CSR related activities and its long term CFP (Chen, 2011). Related to the stakeholder viewpoint is the development of the Social Contracts Theory (Gray et al., 1996, Donaldson & Dunfee, 1999) which is based on the principle that organisations ought to behave in a responsible manner based on implicit and explicit macro-social and micro-social contracts between corporations and various groups of stakeholders within society not only because of instrumental commercial interests but also due to a wider altruistic based sense of duty expected from particular groups of stakeholders within society.

#### **3.5.3 CSR: Approaches & Perspectives**

The increasingly popular viewpoint that an organisation is responsible and accountable to a wide range of stakeholders has in turn led to the

emergence of a broad range of perspectives and approaches focused upon exploring, understanding and informing the development of CSR practices in different countries, cultures, contexts and industries (Crowther & Rayman-Bacchus, 2004; Habisch et al., 2005). For example the text by Crowther & Rayman-Bacchus (2004) reports studies which have explored the development of practices associated with CSR within a wide range of different states in the USA (Mahon & McGowan, 2004), in the European Community (Abreu & David, 2004) and in a wide range of different contexts such as the extent to which governments act in a socially responsible manner (Mahon & McGowan, 2004) and the effects of bioengineering on biodiversity (Topal & Crowther, 2004). Furthermore the text by Habisch et al. (2005) which adopts a European perspective provides an interesting overview of the various approaches related to CSR that have been adopted within 23 European countries within a wide range of different contexts in both the private and public sectors. The text edited by Crowther & Jatana (2005) on the other hand adopts an international perspective and reports on a wide range of international dimensions connected to the study of CSR. These include the exploration of the tensions that appear to be inherent as a result of the co-existence of the free market ethos alongside the principles of CSR and an investigation of the relationship between CSR practices and corporate reputation. As a result of this diverse range of approaches and perspectives related to CSR, a broad range of theoretical and practical models have been developed in order to attempt to provide practical mechanisms for organisations to design, implement, monitor, measure and evaluate the effectiveness of their CSR activities.

A number of useful stakeholder analysis models have been developed such as those of Carroll (1979; 1996), Freeman (1984), Frederick et al. (1992) and Jones (1995) amongst others. These models have sought to develop practical mechanisms to enable organisations to undertake a systematic attempt to identify their key stakeholders in order to be able to develop, implement, monitor, measure and evaluate the effectiveness of their CSR activities. Furthermore many organisations already voluntarily report the extent of their CSR activities within their annual reports or dedicated CSR reports (Jones et al., 2005). Some of the main objective indicators that are widely reported in relation to the evaluation of an organisation's CSR activities and commitments include the Toxics Release Inventory (TRI), AccountaAbility's AA1000 standard based on the Triple Bottom Line reporting, the Social Accountability's International SA8000 standard and the ISO 14000 environmental management standard (Clegg et al., 2011). Over time it appears that organisations across the world appear to be increasingly adopting and implementing CSR strategies and whilst the motives driving this appear to be varied, a recent report identified that over 80% of the companies surveyed by the U.S. Chamber of Commerce and Corporate Citizenship Centre agreed that being a good corporate citizen and engaging in CSR activities improved the company's bottom line (Rochlin et al., 2004). In line with this the following section outlines some of the specific CSR related strategies and practices that have been adopted by organisations operating in the private sector.

#### **3.5.3.1 CSR Strategies & Practice: Private Sector Organisations**

As highlighted earlier in this section over the last four decades organisations globally have become increasingly committed to adopting and implementing strategies related to CSR due to the realisation of the

benefits arising from this. These benefits include an improved corporate public image, increased sales, better financial performance and the retention of a more dedicated and loyal workforce (Gupta, 2012).

Furthermore, as alluded to earlier in this section, the increasing global interest in CSR has resulted in an ever expanding range of publications in both the practitioner and academic domains covering a broad spectrum of CSR related issues related to organisations operating in local, national and international contexts (Crowther & Rayman-Bacchus, 2004; Abreu et al., 2005a, b; Habisch et al., 2005; Jones et al., 2005; Burchell & Cook, 2006; Idowu & Papasolomou, 2007; Silberhorn & Warren, 2007; Nielsen & Thomsen, 2009). Whilst it is not possible to provide a comprehensive review of all the studies in the field, the following section provides some examples to reflect the diversity of some of the studies reported in this field.

The study by Jones et al., (2005) focuses upon the retail industry in the UK and provides an overview of the range of CSR strategies that have been adopted by the UK's top ten retailers. This study draws on secondary research data through examining the CSR reports of the top ten UK retailers along with information related to their CSR activities as publicised on their websites. The study reports the implementation of a wide range of CSR practices by these organisations in respect of their commitment to the environment, a fairer approach to trade within the market place, a better work environment for their employees and a greater contribution towards improving the welfare of the wider community. In another study reported by Idowu and Papasolomou (2007) interesting insights are provided into the broad range of motives underpinning the publication of CSR reports by 20 UK based companies operating across a wide range of industries. These

motives ranged from organisations publishing their CSR reports to primarily satisfy their legal responsibilities to doing so voluntarily in order to meet the ever increasing demands for CSR related information from a wide range of interested stakeholders. Another reported popular reason why organisations publicise their CSR related activities appears to be linked to instrumental motives related to improving the organisation's public image and consequently its financial performance (ibid.). A separate study by Abreu et al. (2005b) which is based upon a survey developed by the Instituto ETHOS of the top ten socially responsible Portuguese enterprises explores the experience and practice of CSR by enterprises operating in diverse range of industries based in Portugal. A more recent study reported by Aluchna (2010) based on secondary research provides a valuable perspective on the extent of the development of CSR strategies adopted by the top ten largest Polish listed companies. This study concluded that the CSR strategies adopted by the Polish organisations appeared to be mainly passive in nature involving for example the provision of regular donations to charities rather than adopting more proactive measures such as engaging in contributing directly towards resolving social problems within society.

An interesting international comparative approach is adopted in a study reported by Silberhorn and Warren (2007) which, through drawing upon primary interviews with senior managers, examined the differences towards CSR adopted by large companies based in Germany and the UK. Whilst this study found some cultural differences influencing how CSR was adopted by organisations in each of these two countries it also found many similarities in the CSR strategies implemented amongst the companies in dealing with community, employee and customer based issues. As far as

the developing world is concerned a study by Sharma & Narwal (2005) provides an interesting insight into the changing context of CSR as adopted by companies in India. Drawing on a quantitative based study involving 187 respondents the study concluded that Indian corporations appeared to be increasingly responsive to the expectations of a wide range of stakeholders by engaging in, for example, activities that explicitly demonstrated their commitment to behaving in a socially responsible manner. Another study drawing on secondary research provides useful insights into the challenges that organisations in developing countries face as they adopt CSR related strategies and practices (Adewuyi & Olowookere, 2010). Other studies have reported interesting issues connected to the adoption of CSR by private healthcare organisations in Asia (Zinkin, 2007; Chigullapalli, 2007) and by organisations in the Lebanese private healthcare sector (Jamaili, et al., 2010). Whilst it is clear that CSR has become a popular concept in the corporate global world for the reasons explained above, interestingly this concept appears to be generally discussed mainly within the context of private sector corporations. This however does not imply that public sector corporations are immune to the principles of CSR and the next section examines the extent to which CSR related practices are also adopted by non-government organisations (NGOs) and public sector organisations.

#### **3.5.3.2 CSR Strategies & Practice: NGOs & Public Sector Organisations**

Although the concept of CSR tends to be discussed mainly in the context of private sector organisations these principles are also applicable to NGOs and public sector organisations where they tend to be discussed in the context of more relevant concepts such as “ethics”, “social responsibility”,

“public accountability” and “citizen orientation” amongst others. Wilson (2000) regards socially responsible behaviour akin to good and ethical behaviour directed at solving social problems while Claver et al. (1999) discuss the concept of a “citizen oriented culture” as one where the notion of “serving the citizen” occupies a central and significant focus within the organisation. It could be argued that unlike the private sector organisations, public sector organisations and NGOs are inherently committed to an altruistic service ethos given the public service nature of their *raison d’être* and therefore the concept of social responsibility can be viewed to be implicitly taken for granted within this context. The need therefore for such organisations to formally adopt and develop CSR related strategies could be considered to be redundant.

Interestingly however many NGOs and public sector organisations have in fact adopted and implemented formal CSR related policies which appear to be as diverse as those existing in private sector based organisations. To some extent it could be thought that this may be attributed to the pressures exercised by governments globally upon their public sector organisations as a result of the implementation of the New Public Management (NPM)<sup>39</sup> movement by various governments designed to replicate private sector practices and values within the public sector organisations in a quest to reduce overall costs and improve efficiency and effectiveness in the day to day activities of public sector organisations.

Furthermore pressures emerging from public expectations for all organisations, irrespective of the sector they operate in, to demonstrate their commitment to behaving in a socially responsible manner may also have contributed towards encouraging many public sector organisations

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<sup>39</sup> See section 2.2.1.1.2 for an outline of the NPM movement.

and NGOs to formally adopt and publicise their CSR related strategies. Testimony to this is the unequivocally growing evidence of the adoption and practice of CSR related strategies globally by NGOs and public sector organisations.

Whilst it is outside the scope of this thesis to provide a full review of the vast range of the examples in this field, the following instances provide some insight into the extent to which NGOs and public sector organisations appear to have adopted and publicised formalised CSR strategies. A general review of the websites of NGOs and public sector organisations reveals the prevalence of CSR strategies that are interestingly mainly externally focused, in terms of, for example the provision of aid and services to local communities and responses to environmental concerns. For example the British Red Cross reports that “(it) helps people in crisis, whoever and wherever they are. We are part of a global voluntary network, responding to conflicts, natural disasters and individual emergencies...” (British Red Cross, 2009).

The text edited by Habisch et al. (2005) provides a comprehensive account of the wide range of CSR related policies and strategies adopted within the public sector by the governments of 23 different European countries. With regards to the UK, the Department of Environment (DofE) publicises its CSR strategies on its website in relation to dealing with issues connected to climate change and conservation of energy (Dept. of Environment, 2009). Furthermore a review of the CSR strategies related to public and healthcare organisations reveals that as far as the UK NHS and the Department of Health are concerned, their CSR strategies as publicised on their websites also appear to be mainly externally focused. These strategies in the main emphasise aspects related to the NHS’s contribution to improving the



social environment through for example reducing its carbon footprint, creating jobs, developing local communities and developing ethical corporate policies such as those relating to purchasing and supply (Dept. of Health, 2007; NHS, 2007). As far as public healthcare organisations outside the UK are concerned a study of the Portuguese public healthcare system reported by Abreu et al. (2005a) concluded that there was an urgent need for the development by the Portuguese government of a dedicated CSR strategy within its healthcare system. Another study by Kakabadse & Rozuel (2006) based on a case study of a local French hospital explored the benefits for the French healthcare system of the adoption of policies and strategies related to CSR. Similarly a study by Rohini & Mahadevappa (2010) which was based on a case study involving five public hospitals in India provided interesting insights about the merits of the public hospitals adopting a formal strategy towards social responsibility through drawing on the views and perceptions of the key stakeholders in these hospitals.

It is evident from the preceding sections that organisations world-wide based in the private, public and NGO sectors are increasingly engaging in a broad range of CSR related practices so as to address the interests of a diverse group of internal and external stakeholders. Whilst it is widely accepted that the extent of an organisation's success in effectively implementing its CSR strategy is to a large extent contingent upon the commitment, contribution and support demonstrated by its staff towards this strategy (Collier & Esteban, 2007) it would be useful in this context to examine the extent to which organisations explicitly recognise the commitment and contribution of their staff within their publicised CSR strategies. The next section therefore provides a review of the research and literature related to the extent to which organisations in the private, public

and NGO sector recognise the commitment and contribution of their staff within their publicised CSR strategies.

### **3.5.3.3 CSR Practice: Recognition of the Commitment & Contribution of Staff within the CSR Strategies of Organisations in the Private, Public & NGO sectors**

The wide range of definitions and approaches towards CSR is reflected in the multitude of different applications of CSR by various organisations. Organisations tend to mainly publicise their CSR strategies via sections within their annual reports or dedicated CSR reports and/or via the internet (Jones et al., 2005).

Interestingly unlike NGOs and public sector organisations it appears to be mainly private sector organisations that tend to make an explicit statement relating to the commitment and contribution of their staff towards the organisations' CSR endeavours within their publicised CSR strategies (Merali, 2010). For example Cadbury Schweppes emphasises the commitment of its staff as follows: "We ask our people to put Cadbury Schweppes' values into action in the things they do and say every day. We expect all of our people to recognise and value the full range of individual contributions, ideas and cultures and work with them to create maximum value for the organisation and its stakeholders...we expect all our managers to live up to our values..." (Cadbury Schweppes, 2006, p. 12).

Johnson & Johnson similarly emphasise the commitment and contribution of its staff to the organisation's CSR strategy: "At all levels, Johnson & Johnson employees are committed to ethical principles outlined by our Credo...employees throughout Johnson & Johnson are periodically

surveyed to be sure that the company conducts business in accordance with its Credo” (Johnson & Johnson, 2009).

Likewise Tesco “stresses in its CSR approach the significance of looking after its employees so that they, in turn, can look after the customers (which) is central to the company’s core values...” (Jones et al., 2005, p. 889). John Lewis also through its Golden Jubilee Trust “grants awards, covering pay and benefits, to allow employees to take up to six months leave from their work (so as to be able to work) with a registered UK charity (in order to enable) a focus on being “good neighbours” within the local community (which) is another general CSR theme” (ibid., p. 890).

Shell within its publicised CSR strategy also explicitly highlights its individual employee achievements through stating that “a total of 160 employees...participated and made a contribution to improving the environment and building trust in the community” (Shell, 2005). Similarly VocaLink, which is a relatively small organisation engaged in the processing of specialist payments for the financial industry employing 750 staff in the UK and Amsterdam explicitly recognises the significance of its staff within its publicised CSR strategy which states that they “use CSR to nurture, engage and motivate (their) staff” (Lombard, 2012).

This explicit and implicit emphasis of the commitment of an organisation’s staff (including managers) in achieving the organisation’s CSR endeavours within its publicised CSR strategy is for example also evident in UK based private sector healthcare organisations such as Bupa. Bupa’s CSR based website reported that “a team of intrepid management trainees from Bupa UK Health Insurance had just returned from an intense five days in India

where they worked with a charity in Jaipur, the VIhaan Project, to help improve education and business opportunities in the area” (Bupa, 2009).

In contrast a general review of the websites of NGOs and public sector organisations reveals the reporting of CSR strategies that tend to be mainly externally focused such as, for example, providing aid and services to local communities and responding to other environmental concerns such as reducing their carbon footprint. There appears to be a general absence of any explicit or implicit reference to the contribution and commitment of the organisations’ staff towards achieving the organisations’ CSR endeavours within their publicised CSR strategies. Instead the emphasis is placed upon what the organisation does for external stakeholders rather than what the internal stakeholders such as the employees do (or are motivated to do) in order to achieve the organisation’s CSR goals.

An examination of the publicised CSR strategies of some of the NGOs and public sector organisation supports this view. For example, the British Red Cross reports that “(it) helps people in crisis, whoever and wherever they are. We are part of a global voluntary network, responding to conflicts, natural disasters and individual emergencies...” (British Red Cross, 2009). The Department of Environment (DofE) also adopts an essentially externally based CSR strategy in terms of dealing with issues connected to climate change and conservation of energy (Dept. of Environment, 2009) and similarly the CSR strategies adopted by the UK NHS and the Department of Health are externally focused in for example creating jobs, developing local communities and developing ethical corporate policies such as those relating to purchasing and supply (Dept., of Health, 2012; NHS, 2007, 2012).

Interestingly a review of the websites of various NHS Trust hospitals reveals that in addition to the UK NHS's publicised CSR strategy many NHS Trusts also appear to have also developed their own local approaches towards the adoption of their CSR related strategies which again tend to be mainly externally focused (Barnet & Chase Farm Hospitals NHS Trust, 2012; Bolton NHS Primary Care Trust, 2012). There appears to be a general absence of any explicit indication of the commitment or involvement of staff within the NHS's and the various individual hospital Trusts' publicised CSR strategies.

Whilst the public sector has tended to be regarded as a role model for the private sector in its approach to transparency and commitment to CSR (Michael & Gross, 2004) it has been the private sector corporations as discussed earlier<sup>40</sup> that appear to, for various reasons, be actively promoting their employees' commitment to socially responsible behaviour within their publicised CSR strategies (Moir, 2001; Jones et al., 2005; Lombard, 2012). Although many studies have reported that public sector staff including NHS managers hold altruistic based values (Blau, 1963; Mackenzie, 1995; Mellett & Marriott, 1995; Clarke & Yarrow, 1997; Young, 1999; Boyne, 2002; Mannion et al., 2010; Jacobs et al., 2013), apart from the study reported by the author in 2010, there appears to be a general dearth of published research exploring the potential merits of actively promoting this commitment and contribution of staff within the publicised CSR strategies of public sector organisations such as the NHS. In line with this the final objective this study therefore seeks "to critically evaluating the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers".

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<sup>40</sup> See the beginning of this section.

A detailed discussion based on the findings of this study in relation to the extent to which the CSR strategy adopted by the NHS reflects the NHS managers' personal contribution and commitment in the context of the findings of this study is provided in chapter 8.

### **3.6 Concluding Remarks**

This chapter has provided a literature review relating to the concepts of Organisation Culture, New Institutional Theory, Self and Work Identity Theory and Corporate Social Responsibility which make up the overarching theoretical framework underpinning this study.

This overarching framework will provide a valuable underpinning towards achieving the aim and objectives of this study. As explained in this chapter the theories of Organisation Culture provide a useful platform from which to explore and discuss the findings associated with the first objective of this study in relation to examining the NHS managers' perceived core values and the extent to which these relate to a commitment towards working in a socially responsible manner. The findings associated with this objective will in turn be drawn upon to explore and discuss the findings connected to the second objective of this study relating to the healthcare managers' views of their public image and the implications arising therein. New Institutional Theory provides a valuable relevant background theoretical framework for exploring this objective. The literature related to identity theory and in particular Alvesson & Willmott's (2002) theoretical model proves particularly useful in underpinning the third objective of this study which examines the healthcare managers' self and work identities through building upon the insights developed through the first two objectives of this

study. Lastly the concept of Corporate Social Responsibility is central to exploring the final objective of this study which again builds upon the findings connected to the other three objectives driving this study.

The relatively disparate fields of study associated with Organisation Culture, New Institutional Theory, Self and Work Identity Theory and Corporate Social Responsibility are therefore drawn upon in an integrated manner as a valuable interlinked framework to explore and discuss the findings emerging from this study so as to develop a more holistic and deeper understanding of the issues central to the aim and objectives of this study.

The next chapter provides the rationale underpinning the selection and adoption of the research methodology in this study in order to support and facilitate the achievement of the study aim and objectives.

## **Chapter 4: Methodology**

### **4.1 Introduction**

This chapter provides the rationale underpinning the selection and adoption of an appropriate research methodology to support and facilitate the achievement of the aim and objectives of this study. The chapter begins by revisiting the research aim and objectives followed by a consideration of the key research methodological approaches available to the researcher including an examination of their ontological and epistemological basis. This is followed by an examination and evaluation of the range of research designs, methods and approaches to data analysis. The rationale leading to the adoption of the research methodology to support this study is discussed throughout the various sections of this chapter.

### **4.2 Research Methodology: Considerations, Rationale & Choices**

It would be useful to start this chapter by restating the research aim and objectives of this study so as to set the context for the rationale supporting the selection and adoption of the appropriate research methodology for this study. As stated in chapter 1<sup>41</sup>, this research study aims to “critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21<sup>st</sup> century NHS managers”. The following four objectives have been developed to facilitate the achievement of the research aim:

1. To identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner.

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<sup>41</sup> See section 1.3.



2. To explore the healthcare managers' views of their public image and to investigate the extent to which they believe this affects their psyche and their overall commitment and contribution to the NHS.
3. To explore the healthcare managers' self and work identities.
4. To critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers.

As with any research study identifying and adopting an appropriate research methodology supported by suitable research methods is a critical task since this will reflect the extent to which the research aim and objectives of the study will be effectively achieved. Silverman (1999, p. 103) defines "methodology" as "a general approach to studying a research topic. It establishes how one will go about studying any phenomenon". Research "methods" on the other hand are defined as "specific research techniques (which) include quantitative techniques like statistical correlations as well as ...observation, interviewing and audio recording" (ibid., p. 104).

The methodology adopted in this study was therefore essentially determined by exploring the various philosophical approaches and paradigms prevalent in the social sciences and their underlying assumptions relating to epistemology, ontology and human nature (Burrell & Morgan, 1979). The process of determining and selecting an appropriate research methodology for this study began with an appraisal of the key literature relating to research methodologies. This was followed by a detailed review of the various research methods and tools available to the researcher in

order to determine which would prove most effective towards facilitating the achievement of the research aim and objectives.

A review of the literature in this field revealed a complex landscape with competing paradigms and philosophies pertaining to the natural and social sciences underpinned by fundamental assumptions as to what constitutes knowledge (ontology) and how this could be understood (epistemology) (Burrell & Morgan, 1979; Hatch, 1997; Guba & Lincoln, 1994). This chapter will outline and explore these key considerations.

#### **4.2.1 What is Knowledge? - Ontological and Epistemological Considerations**

It is imperative for any academic researcher to ensure that a suitable research methodology is adopted to facilitate and support the effective examination of the phenomenon or phenomena under investigation in their particular research study. This process involves a critical evaluation of the various methodological approaches available to the researcher including an understanding of their underlying ontological and epistemological assumptions since as suggested by Burrell & Morgan (1979) “all social scientists approach their subject via explicit or implicit assumptions about the nature of the social world and the way it may be investigated” (p. 2).

Ontology is explained by Burrell & Morgan (1979, p. 5) as “assumptions which concern the very essence of the phenomena under investigation...whether the reality to be investigated is external to the individual ...and of an objective nature or the product of individual cognition (and) the product of one’s mind”. Similarly according to Hatch with Cunliffe (2006, p. 12) ontology “concerns our assumptions about reality. Is there an objective reality out there or is it subjective, existing

only in our minds?”. It is therefore important that the researcher explores the ontological assumptions underlying the various methodological approaches about what is the nature of reality in terms of whether it exists independently “out there” to be explored and discovered or is it subjective in relation to the individual’s own world view. An understanding of the ontological assumptions about the nature of reality will influence and shape the epistemological approach adopted in terms of how that knowledge will be explored and understood.

Epistemology on the other hand is defined by Hatch as “a branch of philosophy that concerns itself with understanding how we can know the world. Along with ontology, which concerns what can be known (i.e. the kinds of things that exist), it forms the foundation of all philosophical thinking” (1997, p. 47). Similarly Burrell & Morgan (1979, p. 5) regard epistemology to be “assumptions about the grounds of knowledge - about how one might begin to understand the world and communicate this as knowledge to fellow human beings”. An understanding of these two concepts (i.e. ontology and epistemology) is therefore fundamental in order to fully comprehend and appreciate the complex philosophical landscape pertaining to the natural and social sciences.

Those who assume an objectivist ontological position essentially believe that “reality exists independently of those who live in it” (Hatch with Cunliffe, 2006, p. 12). Reality according to this view is deemed to have an objective existence which can be explored and understood through adopting a positivist epistemological position. “Positivist epistemology assumes you can discover what truly happens in organizations through the categorizations and scientific measurement of the behaviour of people and systems” (ibid., p. 13). On the other hand there is a competing view that

reality is inherently subjective since it is believed to be based upon people's experiences and interactions with each other. Therefore according to this view reality as such only exists once it is experienced and given "meaning" (ibid.). Hence there can be "many different understandings and interpretations of reality and interpretive epistemology leads us to use methods designed to access the meanings made by others and describe how they come to make those meanings" (ibid., p. 13). The fundamental ontological position adopted by the researcher regarding the nature of reality thereby influences and shapes the researcher's epistemological position in terms of "how" that reality or knowledge can be explored and understood.

An approach to understanding knowledge and truth within the social sciences is therefore fundamentally rooted in the ontological and epistemological perspective that is adopted since as advocated by Burrell & Morgan (1979, p. 3) "different ontologies, epistemologies and models of human nature are likely to incline social scientists towards different methodologies". An understanding of some of these competing philosophies prevalent in the natural and social sciences, as outlined below, provide the necessary background context and rationale underpinning the adoption of the research methodology deemed to be appropriately fitting for the achievement of the aim and objectives of this study.

#### **4.2.2 Competing Philosophies: Approaches to Understanding Truth & Knowledge in the Social Sciences**

The natural sciences (such as for example Physics, Medicine, Biology, Botany) are based on the assumption that truth or knowledge exists "out there" and "...independently of those who live in it" (Hatch with Cunliffe,

2006, p. 12) and the search for the truth from this paradigm is therefore based upon scientific methods and measurements (i.e. through adopting a positivist epistemological position). On the other hand within the social sciences there exist multiple paradigms and assumptions based on differing ontological and epistemological positions. Whilst the proponents of naturalism in social science (like Durkheim, Parsons and Merton) adopt a positivist epistemological position, anti-naturalists (such as Geertz, Taylor and Schutz) embrace an epistemological position rooted in phenomenology or interpretivism<sup>42</sup> (Hussey & Hussey, 1997; Lazar, 1999). According to Morgan & Smircich (1980, p. 492) these two positions are regarded as end points on a continuum of core ontological assumptions with the pure objectivist position about the nature of the world appearing at one end of the continuum represented by the positivist and the phenomenologist position represented at the other end of the continuum based on a pure subjectivist view of the world. This continuum is useful for helping the researcher determine the appropriate position to be adopted for exploring the phenomenon of interest in their study. However the position therefore is not simply about determining whether one adopts an objectivist or interpretive epistemological position since as discussed in the following section it is also possible to bridge this dichotomy and in fact it has been argued by some proponents that adopting both approaches can prove valuable for exploring, understanding and verifying knowledge (Lazar, 1999).

#### **4.2.3 Philosophical Tradition of the Naturalists & the Interpretivists**

The naturalists such as Durkheim, Parsons and Merton believe that social life consists of social facts which can be isolated and studied in an

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<sup>42</sup> As explained in the next section (4.2.3).

objective and scientific manner thereby embracing the objective ontological position (Lazar, 1999). Although the naturalists explicitly recognise the interplay of meanings, interpretations and values upon exploring and understanding social facts they believe that these social facts can be isolated and explored in a rigorous and scientific way (ibid.).

On the other hand, interpretivists such as Geertz, Taylor and Schutz are fervent about their views that reality is socially constructed through the perceptions and meanings attributed to social interactions and therefore hold the view that reality is inherently subjective. In this case the existence of multiple realities and truths can only be adequately explored and understood through adopting an interpretive epistemological position (ibid). In fact Geertz emphasises the nature of reality as being subjective and socially constructed through one of his most famous quotes:

*“...man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning”* (Geertz, 1973, p. 3).

Whilst the dichotomy between naturalists and interpretivists appears to be firmly entrenched due to their fundamental differences relating to the nature of reality, some social scientists such as Max Weber have attempted to bridge this dichotomy through asserting that a scientific and an interpretive approach should not be regarded as mutually exclusive within the study of the social sciences since in fact both approaches can prove valuable for exploring, understanding and verifying knowledge (Lazar, 1999). According to Lazar (1999, p. 19), Weber recognised the powerful interplay between values and the search for truth or facts since “he

contended that we cannot help but structure what we see according to our values” (ibid., p.19). However whilst Weber recognised the influence of values upon understanding truth and therefore the subjective nature of reality, according to Lazar (1999) he held that “...once we have decided on our topic and framework of analysis, it is the social scientist’s responsibility to determine the facts in a value-free (and objective) manner” (ibid., p. 19). Therefore according to this view point whilst the social scientist needs to be aware of the influence of values upon understanding truth s/he should seek to explore the truth in a value free and objective manner.

At this stage a brief outline of the concepts of structuralism & post-structuralism would be useful in aiding a deeper understanding of the different perspectives adopted within the social sciences in relation to the nature and study of social reality.

#### **4.2.4 Structuralism & Post-Structuralism**

The Structuralist and Post-structuralist movements provide a valuable foundation for exploring some of the deeper issues relating to the differences in approaches adopted by naturalists and interpretivists in understanding the nature of social reality. It is however important to emphasise at the outset that an understanding of the differences between Structuralism and Post-structuralism is far from straightforward and open to interpretation. Structuralism essentially recognises the key role played by language in influencing social reality and reflecting social life.

Advocates of the Structuralist movement such as Claude Levi-Strauss and Ferdinand de Saussure held that subjectivity and social thought was the product of deeply embedded universal structures which lay beneath the

surface of social reality (Manning & Cullum-Swan, 1994; Lazar 1999). Social reality is therefore viewed as being framed by and reflecting these deeper universal rule systems which are regarded to exist “out there” and therefore have an objective basis (Filmer et al., 1999). Since these universal rule systems are common to all societies (whether primitive or modern) and rooted in language systems based on binary opposites (such as good/bad, lawful/unlawful, god/man, etc.) they thereby frame and shape social thought and social reality in society. The individual in society is seen to be a subject of these universal rule systems since as indicated by Manning & Betsey Cullum-Swan (1994, p. 467) “the person is merely the speaking object...persons are in every sense not only the creations of such structures, but manifestations of elements and rules created by social structures”.

Whilst the Structuralist movement dominated social and cultural research until the late 1970s, Post-structuralism has gathered increasing momentum and popularity in this field from the early 1980s onwards (Filmer et al., 1999). Post-structuralism is intricately linked to the Post-Modernist movement which rejects the existence of universal systems and regards language as critical in shaping and creating reality rather than representing and reflecting reality. Post-Modernists reject efforts at a universal understanding (i.e. termed the “grand narrative”) as embraced by Modernists through their “unquestioned value for rationality and ...efforts to develop an integrated theory of the universe based on scientific principles and methods” (Hatch, 1997, p. 44). Instead Post-Modernists believe that “knowledge is fundamentally fragmented...(it) is produced in so many different bits and pieces that there can be no reasonable expectation that it will ever add up to an integrated singular view” (ibid.). Post-Modernists and social constructionists instead emphasise the socially



constructed nature of reality as opposed to reality being construed to have an objective existence (Hatch, 1997). Berger & Luckmann's work (1966) develops the concept of "enactment theory" which was introduced by an American social psychologist named Karl Weick. Enactment theory recognises the subjective basis of how realities are created or "enacted" in the organisational world and this is emphasised in Weick's belief that "managers construct, rearrange, single out and demolish many "objective" features of their surroundings" (Weick, 1969). Drawing on the work of Weick (1969) and Berger & Luckmann (1966), Post-Modernists and social constructionists recognise the socially constructed nature of reality and reject the Modernist notion of the grand narrative. They instead support the view that there cannot be one truth but multiple truths and realities which are enacted and shaped by the sense making and meanings attributed to organisational experiences and interpersonal relationships between different organisational actors (Hatch, 1997). Post-Modernism and Post-structuralism also emphasise the particularly critical and powerful role played by language in enacting, constructing and re-constructing social reality through rejecting the Structuralist notion that social thought is the product of a deeply embedded objectively based universal structure which lies beneath the surface of social reality. Furthermore Post-Modernists focus upon exposing the political nature of reality in order to challenge the Modernist assumption that knowledge is represented in a neutral and unbiased manner.

Having provided an outline of some of the key research philosophies and traditions that map out the complex landscape within the field, the following section identifies the rationale for the research methodology adopted in this study.

#### **4.2.5 Rationale for the Methodological Position adopted in this Study**

Since the overall aim and objectives of this study<sup>43</sup> seek to develop an insight into the healthcare managers' realities, views and perceptions related to the key issues of central concern in this study, it could be argued that a study of "perceptions" is inherently allied to the interpretivist position whereby knowledge is regarded to be subjective and the world deemed to be best understood "by occupying the frame of reference of the participant in action..., by understanding from the inside rather than from the outside" (Burrell & Morgan, 1979: p. 5). In line with this the author of this thesis has favoured the adoption of an essentially subjective based ontological position underpinned by a phenomenological and interpretive approach in seeking to effectively achieve the aim and objectives of this study. On a wider epistemological scale such an approach would be regarded as being allied with the school of German idealism which espouses an anti-positivist epistemological tradition in which knowledge is assumed to be subjective and the social world is regarded as "essentially relativistic and can only be understood from the point of view of the individuals who are directly involved in the activities which are to be studied" (Burrell & Morgan, 1979, p. 5). As reality in the context of this research study is viewed to be the product of an individual's cognition, the most effective way of exploring and understanding the issues relevant to this study was therefore dependent on the extent to which the researcher was able to engage in a meaningful and deep dialogue with each of the healthcare managers involved in the study in order to develop an insight into their day to day realities and their views and perceptions relating to the issues central to this study. Such active involvement of the researcher in the

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<sup>43</sup> As outlined in section 1.3.

research process and consequently in the construction and generation of the knowledge developed through it makes it also important for the researcher to exercise reflexivity throughout the research process. According to Cassell & Symon (2005, p. 20) the term reflexivity “refers to the recognition that the involvement of the researcher as an active participant in the research process shapes the nature of the process and the knowledge produced through it”. The researcher therefore needs to be aware of the influences and implications of his/her active and joint role with the participants in the construction and generation of the knowledge developed from the research process. Being acutely aware of this, a conscious effort in this regards was made by the researcher throughout the course of this study.

Given the qualitative nature and the context of the overall aim and objectives of this study, it was felt that an inductive approach was most suited to support the methodology adopted in this study as opposed to a deductive approach. According to Bryman (2001, p. 8) in a deductive based research study “theory and hypothesis...come first and drive the process of gathering data” whilst in an inductive approach “theory is the outcome of research...the process of induction involves drawing generalizable inferences out of observations” (ibid., p. 10). An inductive approach allowed for the key issues that became central to this study to emerge from the primary research interviews rather than through a deductive approach whereby the determination of a specific research question or hypothesis would be formulated from the outset and which would then be answered or tested during the research process. This approach is also in harmony with the “grounded theory” approach to developing theory. Grounded theory as explained by Glaser & Strauss (1967) provides for the development of theory in a cyclical form from qualitative data. In the grounded theory

approach “theory is generated by observations rather than being decided before the study...the purpose of grounded theory is to build theory that is faithful to and which illuminates the area under investigation” (Hussey & Hussey, 1997, p. 70). This cyclical approach allowed the researcher at various key stages during the research process to reflect upon the findings collected and analysed so far with a view to determining further appropriate objectives in order to drive the study forward within the context of the overall aim and objectives of the study. Furthermore this cyclical approach facilitated the emergent nature of the research objectives in this study. So for example the findings associated with the second research objective which related to “exploring the healthcare managers’ views of their public image” proved significant in shaping the third research objective relating to “exploring the healthcare managers’ self and work identities”.

Overall therefore a subjective based ontological position was adopted in this study as this was deemed fitting to support the achievement of the phenomenological and interpretive nature of the research aim and objectives. In line with this the inductive approach driving the study allowed for the key issues that became central in this study to emerge from the research process. The next section provides the rationale for the selection of the research design befitting the methodological approach adopted in this study.

### **4.3 Research Designs & Methods**

Having determined the methodological approach underpinning this study, it was important to ensure that a fitting research design supported by suitable research methods was adopted in order to facilitate the achievement of the

study aim and objectives. Bryman (2001) makes a clear distinction between research designs and methods of data collection. He defines the former as “a framework for the collection and analysis of data” whilst the latter is viewed to be “simply a technique for collecting data...(which) can involve a specific instrument such as a self-completion questionnaire or a structured interview schedule or participant observation...” (ibid., p. 29). The two main types of research designs (i.e. Qualitative and Quantitative based) seek to answer different types of questions, collect different types of data and produce different types of answers (Bryman, 1995; Barbour, 1999). Qualitative methods are often appropriate for addressing questions of process while quantitative methods are more effective for addressing questions of statistical prevalence, causality, the relationship between variables and measuring outcomes.

The relative merits and limitations of the qualitative and quantitative research designs were considered carefully in order to determine the most suitable approach to be adopted for this study. The next section outlines the rationale underpinning the selection and adoption of the final research design and methods to support this study.

#### **4.3.1 Qualitative & Quantitative Research Designs & Methods**

The subjective based ontological position adopted in this study was fundamental in determining the adoption of the qualitative research design befitting the aim and objectives of this study. The central focus of a qualitative research design is upon gathering data which is rich in its depth and value so as to be able to develop an insight into the participant’s perspective of the world in relation to the issues under study. This is highlighted by Bryman (1995, p. 135) who states “qualitative research is a

research design which reveals many different emphases from quantitative research...the most significant difference is the priority accorded to the perspectives of those being studied rather than the prior concerns of the researcher, along with a related emphasis on the interpretation of observations in accordance with the subjects' own understandings". This quest for a deep insight into the participant's world is what the "advocates of qualitative research perceive to be prerequisites for the study of social reality..." (ibid., p. 136).

On the other hand quantitative research designs are generally driven primarily by a scientific approach towards the collection and analysis of data (ibid.). This approach is normally underpinned by a "positivist, normative or functionalist paradigm" (Cassell & Symon, 2005, p. 2). The use of scientific based research methods such as questionnaires, laboratory experiments and surveys often also facilitate the deductive approach adopted within a quantitative research design (Silverman, 2007). The data analysis associated with this approach is primarily based on statistical measures based on "content analysis in which researchers establish a set of categories and count the number of instances that fall into each category" (ibid., p. 19). However Bryman (1995) suggests that caution is exercised against making an overly simplistic distinction between quantitative and qualitative research designs based purely on the extent of quantification when he states that such a distinction would be "extremely misleading (since) qualitative researchers are not averse to quantification as such, and often include some counting procedures in their investigations (whilst) quantitative researchers sometimes collect qualitative material for their investigations" (p. 24). In fact Ong (1993) observed that the quantitative-qualitative divide is a "smoke-screen" because in reality researchers do not

always adopt “pure methods” but instead tend to combine the two approaches either explicitly or implicitly. Bryman (1989) has also argued that the distinction between quantitative and qualitative methods is really a technical matter with choice dependent upon the specific research question one wishes to answer. Therefore depending on the nature of the research problem being investigated the researcher can adopt a more pragmatic multi-method approach towards the development of an appropriate research design and in fact such an approach has often been used in relation to research undertaken within the health service setting (Barbour, 1999).

The decision as to whether to adopt a dominant qualitative or quantitative research design or for that matter a multi-method approach is therefore essentially based on the fundamental approach adopted by the researcher towards investigating the phenomena of interest in the study. Since an interpretive methodology<sup>44</sup> has been adopted in this study, a predominantly quantitative based research design driven by a positivist or functionalist approach was therefore discounted since this was deemed to be an inappropriate and unsuitable basis to facilitate the collection of data required to meet the aim and objectives of this study. This of course doesn't mean that there could be no measurement techniques underpinning this study since as advocated by Bryman (1995), a qualitative research design can also accommodate quantification techniques to some extent depending on the aims of the study and the nature of the research data to be collected. Whilst as discussed later in this section, although this study adopted a predominantly qualitative research design, this approach was supplemented by the adoption of a short structured questionnaire designed

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<sup>44</sup> As outlined in Section 4.2.5.

to capture the demographic and professional profile of each of the interviewees.

Since the aim of this research study was to develop an insight into the healthcare managers' realities views and perceptions on a range of issues in order to allow the key themes central to this study to emerge through an inductive approach, a predominantly qualitative research design seemed the most appropriate approach for this study. This approach allowed for a much greater emphasis to be placed upon seeking to understand the world from the point of view of the subjects who participate in it (ibid., 1995). In terms of the suitability of a particular type of a qualitative research design, the "case study" based approach is regarded to be closely allied with qualitative research designs (ibid., 1995). Bryman (ibid., p. 170) argues that "most qualitative research is in fact a form of case study". The case study approach has been defined as "a research study which focuses on understanding the dynamic present within a single setting" (Eisenhardt, 1989, p. 534). Furthermore it also provides "an extensive examination of a single instance of a phenomenon of interest" (Hussey & Hussey, 1997, p. 65). Bryman (1995) points out that although case study analysis usually involves an in-depth study of one organisation, a study of two or more organisations is not uncommon. Furthermore according to Miles and Huberman (1994, p. 435) "looking at multiple actors in multiple settings enhances generalizability; the key processes, constructs, and explanations in play can be tested in several different configurations...each configuration can be considered a replication of the process of question under study. Multiple cases also identify configurations (of actors, of working arrangements, of causal influences) that hold in some settings but not in others". It was therefore decided in this study to adopt elements of a



case study based approach involving two organisations each operating within the public and private UK healthcare sectors<sup>45</sup> in order to increase the generalisability along with the validity and reliability of this study.

Determining the research sample for this study was a significant consideration since the research findings generated from the study would need to be defended in terms of their validity, reliability and generalisability.

Whilst there are many different approaches to determining the research sample, each with their own merits and drawbacks (Bryman, 1995; Cassell & Symon, 2005; Denscombe, 2005), according to Denscombe (2005, p. 12) “basically there are two kinds of sampling techniques that can be used by social researchers...probability sampling and non-probability sampling”. The former technique aims to select a representative cross section of the whole population within the research sample through various approaches such as random, systematic, stratified or quota sampling amongst others. The non-probability sampling technique is based on the purposive, snowball and theoretical sampling approaches whereby the research sample does not represent the whole population. The probability sampling technique was deemed to be impractical for this research study since this would have required the inclusion of a cross section of the entire population of healthcare managers within the research sample. Instead the purposive sampling approach based on the non-probability sampling technique was found to provide a more practical approach for determining the sample population for this study.

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<sup>45</sup> As outlined in the next section (section 4.3.2).

Schwandt (1994, p. 202) argues that “many qualitative studies employ ...purposive sampling methods. They seek out groups, settings and individuals where...the processes being studied are most likely to occur”. Purposive sampling in this research study context involved targeting healthcare managers working in local healthcare organisations that were deemed to be suitable for the context of this research study and who would be willing to be involved in this research study. Whilst this has the advantage of dealing with the more practical and logistic aspects of this study, the drawbacks of such an approach relate to the questions raised about the validity, reliability and generalisability of the research findings emerging through the purposive sampling approach.

When determining the research design and methods of data collection the concepts of validity, reliability and generalisability need to be given careful consideration. According to Bryman (1995, p. 55) “reliability refers to the consistency of a measure” whilst “the validity of a measure raises the issue of whether it really relates to the concept that it is claimed to measure” (ibid. p. 57). Reliability therefore relates to the degree to which research findings can be repeated using the same methods whereas validity relates to the extent to which research findings accurately represent what is happening in the situation (Hussey & Hussey, 1997). Generalisability on the other hand refers to the extent to which the sample research findings can be applied to the wider general population (Hartley, 1995). As examined in more detail later in this chapter these issues of reliability, validity and generalisability were therefore given careful consideration during the determination of the adopted research design and methods since the final outcomes or conclusions of the study will be considered in relation

of the extent of the validity, reliability and generalisability of the data collected and analysed during this study.

Having determined the adoption of the qualitative research design it was then important to identify and adopt appropriate and suitable research methods which would be in harmony with this adopted research design. According to Bryman, (1995) the main research methods associated with a qualitative research design are participant observations and interviews (both unstructured and semi-structured).

Participant observation is a research method whereby the researcher collects data through observing the behaviour and experiences of the subjects in their routine contexts (Waddington, 2005). On the other hand qualitative research interviews are defined by Kvale (1983, p. 174) as “an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena”. Since the research aim and objectives relating to this study are based on developing an insight into the realities, views and perceptions of healthcare managers related to a wide range of key issues and themes central to this study, interviews rather than participant observations appeared to provide an ideal opportunity to develop a meaningful and deep dialogue with the healthcare managers involved in the study. Participant observations would also have proved impractical and overly time consuming given the overall scope of the study.

According to Denscombe, (2005) some of the common types of research interviews include structured, semi-structured and unstructured interviews along with focus groups. Whilst structured interviews involve the researcher asking respondents a series of predetermined and standardised

questions which tend to restrict the range of responses, the semi-structured interviews allow for more flexibility in terms of the sequence and range of questions asked and allows the respondent greater opportunity for flexibility in terms of the range and depth of responses. Unstructured interviews provide an opportunity for the interviewer to be much less directive in terms of the questions being asked and to take on the role of someone prompting the respondent to discuss ideas or views around general issues or themes of central concern in the study. Focus group interviews have become popular relatively more recently and involve the interviewer discussing a particular set of ideas or views collectively with a small selected group of individuals rather than separately with each individual.

Whilst each type of interview approach has its relative merits and drawbacks, it was decided in this study to adopt semi-structured interviews since this approach allowed the interviewer to elicit the healthcare managers' views and perceptions on a limited range of pre-determined issues whilst also allowing flexibility to change the sequence of questions asked and diverge from them to some extent when deemed appropriate. This allowed for the development of a more natural conversational environment where the interviewer was able to explore the issues and themes that emerged during the interview session and encourage the respondent when appropriate towards providing deeper insights into pertinent issues as they emerged. However the drawback of this approach is that it relies on data obtained from potentially time consuming interviews and dialogues with the possible consequence of data overload. As far as the issues of validity and reliability are concerned, relying on data collected through this approach could be argued to lend itself to relatively high

validity since it extracts and captures data that is rich in explanation and analysis.

On the other hand, as indicated by Hussey & Hussey (1997) the case study approach does not merit well as far as the issues of reliability and generalisability are concerned due to the unique nature and context of the case study. However this concern was mitigated to some extent in this study through, as outlined earlier in this chapter, adopting elements of a case study research design involving two organisations each operating within the public and private UK healthcare sectors. Whilst a relatively small number of healthcare managers were interviewed in this study and the study was only limited to the London geographical sector<sup>46</sup>, it could be argued that as explained in the next section the emergence of similar issues during the interviews in this study and those undertaken by the author in two previous separate studies enhances the extent of the reliability and generalisability of the findings of this study. This method of data collection at different times and from different sources is referred to as “data triangulation” (Easterby-Smith et al., 1991) and the determination of similar conclusions from such data is also recognised to increase the validity and reliability of the study findings.

In conclusion, having evaluated the key research designs and methods available to the researcher, in order to achieve the aim and objectives of this study it was decided to adopt a predominantly qualitative research methodology underpinned by elements of a case study research design. Whilst semi-structured interviews were determined to be the main research method to be used in this study for the collection of primary research data, this was to be supplemented by the use of a short structured questionnaire

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<sup>46</sup> As explained in the next section (4.3.2).

designed to collect the demographic and professional background profile relating to each of the participants interviewed in this study. It could be argued that the methodological approach adopted in this study could be challenged by staunch anti-positivists as not going far enough in attempting to understand the interviewee's world. Such proponents may regard the use of semi-structured interviews as "soft-nosed positivism" (Miles & Huberman, 1984) in so far as believing that there is a likelihood that interviewees may respond somewhat passively to pre-determined interview questions and are thereby more likely to favour the use of ethnographic approaches in order to elicit a deeper and richer understanding of interviewee's world view. Furthermore Asbury (1995) believes that creeping quantification such as the insertion of bogus quantitative trappings, such as graphs, into accounts of very small scale studies has done considerable disservice to the credibility of the qualitative research enterprise. However Miles and Huberman provide a sound defence to this when they conclude: "we believe that the quantitative-qualitative argument is essentially unproductive...we see no reason to tie the distinction to epistemological preference...quantitative and qualitative methods are 'inextricably intertwined' not only at the level of specific data sets but also at the levels of study design and analysis" (1994: p. 41).

The next section provides a detailed outline of the primary research undertaken in this study.

#### **4.3.2 Primary Research**

As explained in the previous section, the primary research adopted in this study is underpinned by a qualitative research methodology. Twenty healthcare managers were exceptionally generous to allow the researcher to

conduct individual one hour face to face semi-structured interviews. Half the managers worked in a London based Acute Care NHS Trust whilst the remaining worked in a large private sector hospital in London. Four of the ten NHS managers who participated in this study had a clinical background whilst the remaining six managers were from non-clinical backgrounds. With regards to the ten private healthcare managers who participated in this study, half had a clinical background whilst the remaining had non-clinical backgrounds. Formal approval was obtained in writing from the Chairperson of the NHS Trust and Chief Executive of the private hospital for permitting the involvement of their respective organisations in this study. Seeking access directly from top management is an approach supported by Crompton and Jones (1988) and this proved valuable because once access had been approved by senior management, the researcher's admission to the organisation became legitimised and supported by formal authority.

The purposive sampling method<sup>47</sup> (Frow & Morris, 1994) was drawn upon to determine the sample group of healthcare managers interviewed in this study. Only one condition was applied in the selection of the healthcare managers which was that they should have at least two years' experience of working in the healthcare environment. This would ensure that they would have adequate experience to draw upon during the interviews in relation to exploring the key issues in this study. Furthermore all the managers interviewed in this study were volunteers and were assured of anonymity so that they felt reassured and free to express their views as frankly as possible during the interviews. In order to ensure the anonymity in relation to the identity of the managers a code was determined for each of them. This has

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<sup>47</sup> The previous section (section 4.3.1) sets out the rationale for the adoption of this approach.

been referred to when citing interview extracts within this thesis. NHS managers with a clinical background are represented with a code prefixed by a “C” while those with non-clinical background are represented by an “Nc”. This prefix “C” has been followed by a number ranging from 1 to 10 to identify each of the ten NHS managers. A similar “C” or “Nc” prefix has also been allocated to the private healthcare managers involved in this study. In order to distinguish them from the NHS managers, the prefix for the private healthcare managers is followed by an alphabetical letter (rather than a number as was the case with the NHS managers). So for example, CA represents a private healthcare manager with a clinical background whereas NcF represents a private healthcare manager with a non-clinical background. This coding proved particularly useful when cross referencing interview extracts from the same manager within different parts of this thesis. All the managers also provided their informed consent to participate in this research study. This is in line with the general ethical protocol involved in undertaking academic research and also complied with De Montfort University’s formal ethical guidelines for conducting research related to the social sciences<sup>48</sup>. Some more specific background information relating to the nature of the NHS Acute Care Trust and the private hospital involved in this study would be useful at this stage.

NHS Trusts differ depending upon the function that they are intended to serve in their community and on this basis NHS Trusts could be broadly divided into Acute Care NHS Trusts (i.e. a Trust where hospitals ran Accident & Emergency departments, Acute in-patient services and out-patient services all within the physical confines of the hospitals) and Community Care Trusts (i.e. where the Trust concentrates on providing

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<sup>48</sup> Ethics approval was sought and agreed through the process of completing the University’s “Advance Approval of Research Activity Involving Human Research Ethics – Business School” form.



intermediate and long term care to patients within the community. Community Psychiatry, Geriatrics and Paediatrics are important and heavily represented areas). The NHS Trust involved in this study is an Acute Care Foundation Trust located in central London and has a longstanding and high profile commitment to medical education providing training of an excellent quality to medical students. It houses a prestigious centre for postgraduate medical education which attracts students from all over the world. On the other hand the private hospital involved in this study is a large long established London based hospital providing both inpatient and outpatient multi-speciality services with extensive acute care facilities. It boasts an excellent international reputation for providing high quality care and treatment to both national and international patients.

It is important to reiterate that as explained in chapter 1<sup>49</sup> the development of the primary research undertaken in this study was largely influenced by the two studies previously reported by the author in 2005 and 2006. These two studies were influential in shaping both the aim and objectives of this study along with the design of the research methodology adopted in this study. The study reported in 2005 involved semi-structured interviews conducted with twenty-eight NHS managers working in three different London based NHS Trusts. That study was concerned with exploring the extent of the NHS managers' commitment to a socially responsible role. The second separate study reported in 2006 involved semi-structured interviews undertaken with twenty NHS managers working in two of the same three NHS Trusts involved in the earlier study and centred upon exploring the extent to which the development of an explicit strategy towards social responsibility in the NHS would positively influence the

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<sup>49</sup> See section 1.2.2.

commitment and contribution of NHS managers. Both the studies adopted a qualitative based methodology with an inductive approach which was similar in nature to the one adopted in the study reported in this thesis. Furthermore five of the NHS managers involved in the study reported in this thesis were also involved in the previous two studies (three of these five managers were interviewed for the second time and the remaining two managers were interviewed for the third time in this study). The repeat interviews provided a useful opportunity for the researcher to re-visit some of the issues that had emerged in the previous interviews in order to explore the extent to which there may have been any changes to the managers' views or perceptions and to explore possible reasons for this. The inductive nature of the previous two studies also proved particularly valuable in identifying and developing new avenues and issues of research that became the main focus in the study reported in this thesis.

The similar nature of some of the issues explored in this study to those reported by the author in the other two separate studies also provided a useful opportunity to compare the findings from this study to those of the previous studies in order to establish the extent of the validity and reliability of the previously reported findings. This also lends a valuable longitudinal basis to the exploration of some of the issues in this study. Hussey and Hussey (1997, p. 62) define a longitudinal study as "a study, over time, of a variable or group of subjects (where) the aim is to research the dynamics of the problem by investigating the same situation or people several times, or continuously, over the period". Such longitudinal based studies conducted in the context of a qualitative approach have been reported to have the added advantage of improving the validity and

reliability of the overall research findings (Stebbins,1992; Hussey & Hussey, 1997).

Furthermore as also explained in chapter 1<sup>50</sup> whilst there were similarities in the methodology adopted in this study with those reported by the author previously there were also some key differences. For instance whilst the previous two separate studies reported by the author involved interviews undertaken exclusively with NHS managers, the study reported in this thesis involved additional comparative interviews with healthcare managers working in a private hospital. The comparative interviews with the private healthcare managers were useful in determining the extent to which the key issues central to this study were unique to the NHS managerial culture or whether they were more pertinent to the wider UK healthcare managerial sector more generally.

The individual face to face semi-structured interviews conducted with each of the healthcare managers in this study lasted for approximately one hour. The interviews with each of the NHS managers were undertaken in their individual offices whilst a special interview room was provided for the interviews with the private healthcare managers. Appendix A provides an outline of the interview schedule used during the research interviews however some flexibility was exercised in terms of the sequence of the questions and their wording so as to ensure that the interviews were conducted in a manner which was conducive to the flow of a natural and relaxed conversation in order to cultivate an informal and frank atmosphere. As is evident from Appendix A, the specific research study objectives played an instrumental role in guiding the development of the interview questions. Each interview was tape-recorded (following

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<sup>50</sup> See section 1.2.2.

permission from the interviewees) and subsequently fully transcribed. The reassurance of confidentiality and the uninterrupted nature of the interviews provided an ideal opportunity to cultivate an environment which was friendly and informal so as to allow the interviewees to feel relaxed and be frank when speaking. Each interviewee was also asked at the start of the interview to complete a short structured questionnaire which aimed to identify their demographic and professional background (see Appendix B for a copy of the questionnaire).

### **4.3.3 Pilot Study**

Johnson & Briggs (1995, p. 64) define a pilot study as one which “involves a small-scale investigation or trial of the materials and methods adopted in search of the study’s general objectives”. As already explained within the previous section the shaping of the aim and objectives of this study along with the design of the primary research involved in this study was largely influenced by the two separate studies previously reported by the author in 2005 and 2006. Given that some of the issues explored in these previous two studies were re-visited in this study, the previous two studies also served as valuable pilot studies enabling the refinement and fine-tuning of the approach adopted in relation to the primary research undertaken in the study reported in this thesis. For example the structured questionnaire used in this study was a revised version of the one used in the previous studies (for instance the questionnaire was revised so as to provide age ranges for interviewees to tick rather than asking the interviewee’s specific age as this was felt by some individuals to be too personal). The interview questions for this study were also adapted such that some of the interview questions used in the previous studies were altered so as to accommodate exploring the views of the private healthcare managers’ involved in this study.

Furthermore question 6 was added to the interview schedule in order to explore in greater depth and more specifically how the healthcare managers felt in relation their perceived public image. The previous two studies also proved valuable in further developing the researcher's interview skills and were additionally also helpful in identifying some practical and technical challenges. For instance during one of the interviews in the previous study the power cable from the recording device was found to be too short to reach the power supply and so it was useful to ensure that an adequate supply of extra batteries were available for future interviews to serve as a back-up.

#### **4.4 Data Analysis**

Bryman (2001, p. 387) highlights some of the challenges faced in analysing qualitative data when he states “qualitative data deriving from interviews...take the form a large corpus of unstructured textual material (which is) not straightforward to analyse”. Furthermore he adds “unlike quantitative data analysis, clear-cut rules about how qualitative data analysis should be carried out have not been developed” (ibid.). These sentiments proved true for this study since the qualitative nature of the methodology underpinning this study generated a large volume of rich data. The following sections provide a rationale for the approach adopted towards the analysis of the data emerging from the semi-structured interviews and the structured questionnaire used in this study.

##### **4.4.1 Analysis of the Semi-Structured Interviews**

Whilst there is a wide range of approaches available to the social scientist for analysing qualitative data generated through interviews such as coding,

content analysis, grounded theory, narrative analysis and secondary analysis (Bryman, 2001; Hussey & Hussey, 1997; Miles & Huberman, 1994), coding has been regarded by Bryman (2001, p. 387) to “feature in most of the approaches”. The overall approach adopted by the researcher towards data analysis will therefore essentially depend upon the specific nature of the research study and the type, extent and scope of the field data collected.

The qualitative nature of the methodology underpinning this study fundamentally influenced the approach adopted to data analysis within the study. The inductive<sup>51</sup> nature of this study as explained earlier also facilitated a grounded theory<sup>52</sup> approach toward the development of theory within this study. Coding was adopted as the main method of data analysis within this study since this method has also been regarded to be not only compatible with grounded theory but also “a key process in grounded theory” (Bryman, 2001, p. 388). As explained earlier, grounded theory has therefore proved to be a useful approach in developing theory based on the findings emerging from this study.

In relation to data analysis Miles & Huberman (1994, p. 56) define codes as “tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study”. Codes and sub-codes were used in this study to identify and isolate both the recurrent and interesting emerging themes following the primary research interviews. Given the inductive nature of this study, this system of using codes to analyse the data collected during the primary research interviews allowed the required degree of flexibility in this study since as indicated by

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<sup>51</sup> An explanation of the inductive approach is provided in section 4.2.5.

<sup>52</sup> See section 4.2.5 for an explanation of grounded theory.

Denscombe (2005, p. 119) “in grounded theory the codes are open to change and refinement as research progresses”. There are various types of codes and approaches to coding available to the researcher for analysing qualitative data which according to Miles & Huberman (1994) include “descriptive” or more analytical “pattern” codes. Denscombe (2005) has termed descriptive codes as “open” codes whereas “axial” codes are more analytical in nature.

Within this study both descriptive and analytical codes were used systematically to categorise and analyse the data collected from the primary research interviews. Each of the interviews had been recorded following permission from the interviewee and all of the interviews were fully transcribed following the interview. The process of coding was done by hand on each of the transcripts rather than using a computer software package since it was deemed that the data generated after each of the interviews was manageable to deal with in this way. Chunks of relevant data within each of the transcripts were systematically coded and organised to generate categories (Bryman, 2001) which in turn led to an identification of the emerging key issues or themes. When it was found that the same code was being repeated too often, the code was broken down into appropriate sub-codes to facilitate the effective sub-categorisation and analysis of the data.

An example of this process of coding is demonstrated in Appendix C where codes have been used in a descriptive context whilst sub-codes have been devised to facilitate the analytic context of the data. As shown in Appendix C, codes and sub-codes have been annotated against various segments of extracts taken from the individual interview transcripts. The use of different coloured highlighter pens during the coding process also helped to

distinguish between the various codes. So for example the analytical based code “mot” was initially annotated against chunks of data from the interview transcripts which related to identifying the “motivation” underpinning the reasons indicated by a specific healthcare manager for joining to work in his/her healthcare organisation. Since this code was later found to be recurring in a number of transcripts, it was subsequently broken down to a sub-code marked “ALT” against chunks of data where the healthcare manager revealed that his/her motivation to join the healthcare organisation was underpinned by an “altruistic” motive. If the manager’s motivation was underpinned by “personal” motives then the sub-code allocated on the relevant segment of transcript was labelled “PERS”. In some cases both these sub-codes (i.e. “ALT” and “PERS” ) were annotated against a relevant chunk of data on the transcript if the manager identified both altruistic motives and personal reasons underpinning their reasons for joining to work in a healthcare environment. Such systematic coding and sub-coding on transcripts allowed for the gradual emergence of key issues and themes which were identified and isolated by further sub-coding. For example, as shown in Appendix C, the main emerging themes have been coded as “CORE VALUES”, “PUBLIC IMAGE” and “IDENTITY”.

In order to categorise, organise and analyse the data in more depth, other descriptive codes were also utilised to provide the context for the data in relation to the demographic and professional profile of the participants. Examples of such codes as shown in Appendix C include: “NHS” (to represent managers working in the NHS); “PH” (to represent managers working in the private hospital); “snr” and “mid” (to represent the seniority of managers in terms of senior or middle ranking managers) and “cl” and “nc” (to represent managers from a clinical or non-clinical backgrounds).



The overall process of coding and sub-coding therefore led to the emergence and identification of four key themes in the context of the aim of this study. These were “NHS Managers & their Perceived Core Values”, “NHS Managers & their Perceived Public Image”, “NHS Managers’ Self and Work Identity” and “NHS Managers & Social Responsibility”. Furthermore these themes were also found to be inter-related in the sense that for example the managers’ core values and their perceived public image had implications for their self and work identities. Each of these four themes forms the main basis for the analysis and discussion of the findings of this study in the subsequent four chapters (i.e. chapters 5-8) of this thesis.

#### **4.4.2 Analysis of the Questionnaires**

As explained earlier in this chapter<sup>53</sup> each of the interviewees completed a short structured questionnaire<sup>54</sup> immediately before the start of the interview. The questionnaire (which took less than five minutes to complete) was designed to identify the demographic and professional profile of the healthcare managers including their length of service and their background experience.

As shown in Appendix D the data collected from the questionnaires provided a useful background profile of the interviewees including their approximate age range, seniority, background training and length of service. Given the rather brief nature of the structured questionnaire, the data collected was easily analysed using a standard Excel spread-sheet software package.

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<sup>53</sup> See sections 4.3.1 & 4.3.2.

<sup>54</sup> See Appendix B for a copy of the questionnaire.

## **4.5 Concluding Remarks**

Following a discussion and evaluation of the key methodological approaches available to the researcher, this chapter has provided the rationale for the identification, selection and adoption of the research methodology supporting this study. The chapter has also detailed the extent of the influence of the two previous separate studies reported by the author in 2005 and 2006 in shaping the research methodology adopted in this study. Given the overall nature and context of this research study a rationale has been provided in this chapter for the adoption of a qualitative based research methodology to facilitate and support the effective achievement of the aim and objectives of this study. The adopted methodology is driven by elements of a case study research design and an inductive approach. The inductive approach in turn facilitated a grounded theory approach towards the development of theory within the study. Given the overall nature and context of the research study, the methodology adopted in this study was underpinned by a subjective based ontological position and an interpretivist based epistemological framework.

Purposive sampling was drawn upon to determine the research sample which comprised of ten NHS managers and ten managers working in a private hospital. Whilst semi-structured interviews were relied upon as the key research method for the collection of the primary data, this was supplemented by the use of a short structured questionnaire designed to collect the demographic and professional profile of each of the participants interviewed in this study. The data collected from the short questionnaires were analysed using a standard Excel spread-sheet software package. All the interviews were fully transcribed before being analysed through the process of coding and sub-coding and some practical examples of this

approach have been outlined in this chapter. This approach to data analysis in conjunction with the grounded theory approach facilitated the emergence and identification of four key themes in the context of the aim of this study which were “NHS Managers & their perceived Core Values”, “NHS Managers & their Perceived Public Image”, “NHS Managers’ Self and Work Identity” and “NHS Managers & Social Responsibility”. Each of these four themes forms the main basis for discussion in the subsequent four chapters of this thesis.

## **Chapter 5: NHS Managers & the NHS Managerial Culture**

### **5.1 Summary of Chapter**

In the context of the aim of this study this chapter addresses the first objective of this study<sup>55</sup> which is to “identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner”. The chapter begins by providing the key findings identified from the primary research with NHS managers and private healthcare managers. These findings are subsequently explored and discussed within this chapter with reference to the broader literature relating to Organisation Culture and more specifically in relation to “NHS Managers & the NHS Managerial Culture” as reviewed in the literature review chapter (chapter 3).

### **5.2 Findings**

In addition to the qualitative based semi-structured interviews undertaken with each of the healthcare managers involved in this study, the managers also completed a short structured questionnaire at the start of the interviews which was designed to identify the manager’s demographic and professional profile. Appendix D provides a summary of the data analysed from these questionnaires.

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<sup>55</sup> As stated in section 1.3.

### 5.2.1 Findings: NHS Managers

One of the key themes<sup>56</sup> that emerged from the analysis of the findings of this study related to the “NHS Managers & their Perceived Core Values”.

When exploring the reasons as to why the NHS managers joined the NHS, six of the managers interviewed (with both clinical and non-clinical backgrounds) reported altruistic motives underpinning their reasons for joining the NHS as exemplified in the following quotes:

**Interviewer: Why did you decide to join the NHS?**

*“I suppose I always knew that I wanted to do something with people, I was one of those people who wanted to do something in what you might call a caring profession...I did consider working in a social services type role as well...”.*

C1: Senior Manager, Clinical background.

*“I suppose our family politics being liberal meant that I had this kind of middle way, sort of public service mixed economy drummed into me from an early age...and so I wanted to work in a caring environment...”.*

Nc7: Senior Manager, Non-clinical background.

*“I’ve never been somebody who was massively ambitious, I prefer to do jobs that I really enjoy and I wanted to work in an environment where you feel you are making a difference...”.*

Nc8: Senior Manager, Non-clinical background.

*“I was interested in looking after people, I suppose the caring background appealed and was aligned with my values...working with people, caring for people was just aligned I suppose with my personality traits”.*

C4: Senior Manager, Clinical background.

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<sup>56</sup> As specified in section 4.4.1.

*"I wanted to work in an area that added value, it wouldn't necessarily have had to be care as long as it was something of public value... (though) I might have become a doctor which is what I wanted to do at one point".*

Nc9: Senior Manager, Non-clinical background.

*"I believe in the NHS and its values and what it's about...I wouldn't feel the same if I worked elsewhere".*

Nc6: Senior Manager, Non-clinical background.

The remaining four managers, from both clinical and non-clinical backgrounds, who expressed other reasons for joining the NHS indicated:

*"I probably did about nine months temping work in various organisations...I started working at the regional health authority as a payroll officer, junior grade, I just loved the environment, loved the people I was working with...".*

Nc5: Senior Manager, Non-clinical background.

*"I fell into nursing".*

C2: Senior Manager, Clinical background.

*"I wanted to go into retailing which I did and worked for a supermarket chain...then I thought no retailing wasn't for me and then I really was just looking for something that would give me an opportunity and the NHS popped up".*

Nc10: Senior Manager, Non-clinical background.

*"The subjects I liked at school were always the science subjects...I was offered a place through the clearing house for dentistry...it wasn't so much a selection as a happening...".* C3: Senior Manager, Clinical background.

When asked whether the managers would repeat their decisions to join the NHS today with the benefit of hindsight of their experiences, nine of the ten managers responded positively with many expressing an emphatic

“yes” to this question. Furthermore as shown in Appendix D on average the NHS managers had worked in the healthcare profession for approximately 27 years. The following quotes capture some of these sentiments:

*“Oh, yes, yes!”.*

C1: Senior Manager, Clinical background.

*“Yes I think I still would”.*

Nc7: Senior Manager, Non-clinical background.

*“I wouldn’t change anything about my career per se...”.*

Nc8: Senior Manager, Non-clinical background.

*“The answer is still yes!”.*

Nc9: Senior Manager, Non-clinical background.

*“I would, I enjoy my job...”.*

Nc6: Senior Manager, Non-clinical background.

*“It’s still the case...I would have no hesitation...”.*

C2: Senior Manager, Clinical background.

*“Yes, I’ve been very happy...”.*

Nc10: Senior Manager, Non-clinical background.

On the other hand the following quote indicated the uncertainty expressed by one manager regarding whether she would repeat her decision to re-join the NHS given the benefit of hindsight of her experiences:

*“I think that’s a really difficult question to answer, I really don’t know. I haven’t regretted what I’ve done but whether I’d choose the same again I really don’t know”.*

C3: Senior Manager, Clinical background.

In summary as far as the NHS managers are concerned, the findings indicate that six of the ten managers, with both clinical and non-clinical backgrounds, reported altruistic motives underpinning their reasons for joining to work in the NHS while the remaining four managers expressed other reasons for choosing to work in the NHS. When asked about whether the NHS managers would repeat their decisions to join the NHS today given the benefit of hindsight of their experiences, all but one of the managers interviewed responded positively with many expressing an enthusiastic “yes” to this question. It is worth noting that the five NHS managers who had been interviewed in separate studies previously did not demonstrate any changes to their previously reported views in relation to this issue. The opportunity for this longitudinal assessment of their views also proved to be particularly valuable to this study.

### **5.2.2 Findings: Private Healthcare Managers**

When exploring the reasons as to why the private healthcare managers decided to work in a healthcare environment, six of the managers interviewed (with both clinical and non-clinical backgrounds) reported altruistic motives underpinning their reasons for seeking to work in a healthcare environment as expressed in the quotes below:

***Interviewer: What were the reasons leading you to work in a healthcare environment?***

*“I liked the fact that I was helping people (and) to do this job you’d have to be caring for people”.*

CA: Middle Manager, Clinical background.

*“The reason behind it is that when I was a small boy, I was about six or seven, I had a lot of allergies and ear infections and there was a nurse who cared for me time after*



*time...so I decided that one day I wanted to do something like she did, like caring for people, and that's why I became a nurse".*

CB: Senior Manager, Clinical background.

*"Since leaving school most of the jobs I've done have been in some form of a caring role...I like caring for people, its part of my nature".*

CC: Senior Manager, Clinical background.

*"It was an overwhelming want to make a difference to health and well-being...that's what got me into healthcare..."*

CD: Senior Manager, Clinical background.

*"When I was younger my mother thought I'd be a nurse...it's all about helping people which is why I was very much drawn to the healthcare sector".*

NcG: Senior Manager, Non-Clinical background.

*"I've always, I suppose, basically been a people's person and so I didn't want to go and work in an office Monday to Friday nine to five pm and so when I left school I did think about nursing...and then one thing led to another and I just kind of decided OK I wouldn't be clinical but I did want to work in hospitals".*

NcI: Middle Manager, Non-Clinical background.

The remaining four managers, three of whom came from a non-clinical background, expressed other reasons for joining to work in a healthcare environment as shown below:

*"I joined healthcare by accident...I actually wanted a career believe it or not in the performing arts..."*

CE: Senior Manager, Clinical background.

*“I wanted to find a profession that was recession-proof and I knew somebody who was working at a hospital...”*

NcF: Senior Manager, Non-Clinical background.

*“It was sort of by chance, I was looking for a job and one of my friend’s uncles worked here and said they have some jobs going...”*

NcH: Middle Manager, Non-Clinical background.

*“Well at the time I had an injury, I had an accident and then I was sent by the solicitors here to do hand physiotherapy on me and as soon as I entered the hospital I liked it, the environment, the decoration...I asked the ladies downstairs if there is any position here...I applied and I was lucky”*

NcJ: Middle Manager, Non-Clinical background.

When asked about whether the managers would repeat their decisions to join to work in the healthcare environment with the benefit of hindsight of their experiences, nine of the ten managers responded positively and in most cases without any hesitation to this question. The following quotes capture some of these sentiments:

*“Yes, I think nursing is one of the greatest jobs in the world...”*

CB: Senior Manager, Clinical background.

*“Absolutely, yeah, absolutely!”*

NcG: Senior Manager, Non-clinical background.

*“Yes, yes definitely...I would definitely have done the same again”*

NcI: Middle Manager, Non-clinical background.

*“Yes, I would...I think it’s a rewarding job and I enjoy it...”*

CC: Senior Manager, Clinical background.

*“Yes, I think I would always have moved into healthcare, the compassion that you come across...I don’t think you can beat that...”.*

CD: Senior Manager, Clinical background.

*“Yes though now and again, I did think did I make the right choice...but now I don’t question it...it was the right thing to do”.*

CE: Senior Manager, Clinical background.

The following quote indicated the uncertainty expressed by one manager regarding whether he would repeat his decision to work in the healthcare environment:

*“That’s too difficult a question because you always think as you get older perhaps what would I have done if I had another chance...perhaps PR?”.*

NcF: Senior Manager, Non-clinical background.

Therefore as far as the private healthcare managers are concerned, the findings indicate that six of the ten managers with both clinical and non-clinical backgrounds reported altruistic motives underpinning their reasons for seeking to work in a healthcare environment whilst the remaining four managers expressed other reasons for choosing to work in a healthcare environment. All five private healthcare managers with a clinical background had previously worked for the NHS (this ranged from between 4.5 years and 12 years). When asked about whether they would repeat their decisions to join to work in the healthcare environment today with the benefit of hindsight of their experiences, nine of the ten managers responded positively and in most cases without any hesitation to this question.

### 5.3 Discussion

The findings associated with the first objective of this study are explored and discussed in this section through drawing both on the broader literature related to Organisation Culture and more specifically in the context of the NHS managerial culture as reviewed in chapter 3<sup>57</sup>. Given the interpretive and qualitative nature of the methodology underpinning this study<sup>58</sup>, this objective is explored in the context of viewing the concept of Organisation Culture as a “root metaphor” in line with the interpretivist perspective<sup>59</sup>. Through recognising the socially constructed nature of reality, the “root metaphor” approach facilitates the development of a deeper and richer insight into the NHS managerial culture in relation to understanding the nature of the core values held by the NHS managers and exploring the extent to which these relate towards a commitment to working in a socially responsible manner.

The findings reported in this chapter demonstrate that the majority (six out of ten) of the NHS managers with both clinical and non-clinical backgrounds had actively sought the opportunity to work in a caring profession such as the NHS due to its strong altruistic ethos. This strong commitment to the NHS demonstrated by the NHS managers interviewed in this study is reinforced not only by their long term on-going employment in the NHS (of about 27 years on average<sup>60</sup>) but also by the view expressed by nine of the ten NHS managers that given the benefit of hindsight of their experiences in the NHS they would repeat their decision to join to work in the NHS. Furthermore this view was often expressed very emphatically and

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<sup>57</sup> See section 3.2.

<sup>58</sup> As detailed in section 4.2.5.

<sup>59</sup> As explained in section 3.2.3.

<sup>60</sup> As shown in Appendix D.

without hesitation. Although the findings of this study only represent the views of ten NHS managers, they serve to reinforce the observations of earlier separate studies reported by the author in 2005 and 2006<sup>61</sup>. In the latter study fifteen of twenty NHS managers with both clinical and non-clinical backgrounds working in two different NHS Trusts also reported that they had actively sought the opportunity to work in a caring based profession underpinned by altruistic values such as the NHS. All but one of the managers interviewed in that study also reported that they would repeat their decision to join to work in the NHS given the benefit of hindsight of their experiences in the NHS. Similarly in the study reported by the author in 2005 involving interviews with twenty-eight NHS managers working in three different NHS Trusts, the majority of the NHS managers demonstrated a commitment to values that were mainly altruistic in nature.

These values included a commitment to patient care and to the NHS, a dedication to the provision of public services, a commitment to improving health and a belief in the provision of free healthcare for all. The similarity between the findings from the study reported in this thesis and those reported by the author previously serve to increase the validity and reliability of the findings reported in this thesis. Since values, as advocated by Schein (1985, p.15), “provide the day to day operating principles by which members of the culture guide their behaviour”, it could be argued that the findings presented in this thesis (and when viewed in conjunction with the findings reported by the author from previous studies) demonstrate that the majority of the NHS managers interviewed had actively sought to work in a caring based environment with an altruistic ethos which was in harmony with their personal value systems.

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<sup>61</sup> As outlined in sections 1.2.2 & 4.3.2.

It could be argued that this commitment to the NHS indicates a strong and inherent commitment towards working in a socially responsible manner. This is particularly significant given NHS managers assume a key role which is central to the effective and efficient delivery of high quality care. Of course it would be naive to assume that the NHS managers' inherent commitment towards behaving in a socially responsible role makes them entirely immune to indulging in momentary short term cynical expediencies.

There were however four NHS managers involved in this study (with both clinical and non-clinical backgrounds) who expressed other reasons for choosing to join to work in the NHS. These included either falling into the job by chance or various personal circumstances which led them to their present job. The finding from the present study is again in line with the findings reported by the author in his previous study in 2006 in which five of the twenty managers interviewed quoted other reasons for joining to work in the NHS (such as relating to personal enhancement and career development). In some cases however these reasons were quoted alongside rather than instead of altruistic based reasons. Uniform values may not be shared by all professional groups within the NHS (or for that matter by all NHS managers) and this could form the basis for recognising the existence of sub-cultures within an organisation (Jackson, 1997; Johnson & Gill, 1993).

It is worth examining the importance of the relative strength of the NHS managers' commitment towards working in an organisation which they perceive to be underpinned by altruistic values. The study reported in this thesis specifically focussed on exploring the strength of this commitment which, as has already been discussed earlier, was found to be deeply

rooted. Numerous other studies (Blau, 1963; Mackenzie, 1995; Mellett & Marriot, 1995; Clarke & Yarrow, 1997; Young, 1999; Boyne, 2002; Hewison, 2002; Le Grand, 2006; Exworthy et al., 2009; Granter & Hyde, 2010; Pattison & McKeown, 2010; Mannion et al., 2010; Jacobs et al., 2013) have also reported that public sector staff (including NHS workers) demonstrate a commitment to altruistic values, however a closer examination of these studies shows that this conclusion has often tended to be drawn indirectly and rather obliquely.

For example Blau's study (1963) has been popularly cited for supporting the view that public sector workers hold altruistic based values but interestingly on closer inspection the main intention of Blau's study was not in fact to examine the values of public sector workers but was instead primarily designed to explore the interpersonal relationships within two US public sector organisations and to see how these relationships affected the nature of their bureaucratic functioning. However, in the course of that investigation one of the questions workers were asked during the primary research interviews was "when do you get a special kick out of your job?" and a common answer to this question was that they derived satisfaction from helping members of public during the course of their job (ibid., p. 83-84). This response was taken to imply that public sector workers held a commitment to altruistic based values.

Blau's study (ibid.) was not specifically designed to explore the relative strength of this commitment held by the workers. It did not investigate if the workers had actively sought to work in the public sector so as to satisfy a personal inherent commitment to public services or whether they had just enjoyed the chance opportunity to help members of the public during the course of their work. A desire to actively seek to work in an organisation

with a strong altruistic ethos in line with one's own personal value systems would imply a far stronger intrinsic commitment to the organisation's altruistic ethos.

Likewise the same issue is highlighted by Boyne (2002) following his comprehensive review of 34 empirical studies examining the differences between managers working in the public and private sectors. Whilst Boyne highlighted that the majority of the studies demonstrated that public sector managers had a greater commitment to serving the public than their private sector counterparts, he asserted that "none of the studies attempted to deal with the methodological problem by testing whether the actual behaviour of public managers is more strongly oriented towards the 'common good'. In addition it is unclear whether the distinctive values of public managers precede, or are a function of, employment in the public sector" (ibid., p. 113).

As regards studies that are concerned with NHS staff, Mellett & Marriott's study (1995) reported that the majority of NHS staff, based on the completion of 203 questionnaires, demonstrated a commitment and dedication to patient care. A closer examination of this study however reveals that the main focus was in fact to explore the extent to which economic considerations influenced the overall NHS agenda. One of the assertions in that study was that NHS staff held altruistic values but this was based on how importantly they ranked a question which asked them "the extent to which they wanted to give the best service to patients" (ibid., p.10). The study did not go on to specifically explore the reasons behind their responses to this question.



Likewise a study by Mackenzie (1995) which was based upon a combined qualitative and quantitative methodology surveyed NHS staff in a single NHS Trust and concluded that “staff showed loyalty to the organization and to their clients (and that) the majority of respondents felt they provided high quality care...” (ibid., p. 71). As with the other studies discussed above it is worth noting that this issue was one of a number of aspects under investigation rather than being of central importance to that study’s aims and as with all these studies a deeper analysis of the motives underpinning these sentiments reported by the staff appears not to have been explored. In a similar vein the commitment shown by clinical and non-clinical NHS staff towards altruistic based values was inferred from qualitative based interviews in the studies undertaken by Clarke & Yarrow (1997), Exworthy et al. (2009), Granter & Hyde (2010), Mannion et al. (2010) and Jacobs et al. (2013) but in none of these studies has the strength of the commitment shown by staff to these altruistic values been explicitly examined. Furthermore a study by Young (1999) also reported that healthcare managerial staff held altruistic based values, however this study was limited in scope since it comprised interviews with only five managers all of whom had nursing backgrounds and all worked within one NHS Trust. It could be argued that it is not unsurprising that these managers held altruistic based values since they came from a clinical based vocation and their training was in a caring based profession (i.e. nursing).

Whilst the findings from these various studies discussed above are a valuable contribution in demonstrating that public sector workers including NHS staff hold altruistic based values, an explicit exploration of the relative strength of public sector workers’ inherent commitment to these values appears not to have been explored in any great depth. An

understanding of the relative strength of the public sector workers' commitment towards altruistic based values would also provide an insight into the extent to which they afforded priority towards working in a socially responsible manner. The findings reported in this thesis, through an explicit examination of the motives underpinning the NHS managers' reasons for choosing to work in a healthcare environment demonstrates that the majority had actively sought the opportunity to work in a caring profession underpinned by altruistic values. Furthermore nearly all of them reported that they would repeat their decision to work for the NHS with the benefit of hindsight of their experiences (and it is also worth noting that the average number of years worked by the managers in the healthcare profession was approximately 27 years<sup>62</sup> thereby reinforcing the level of their dedication and commitment to the NHS). Overall the findings in the study reported in this thesis and their similarity to findings reported by the author in earlier separate studies in 2005 and 2006 would suggest that the NHS managerial culture is characterised to a large extent by a strong commitment and dedication to altruistic based core values.

With regards to the private healthcare managers interviewed in this study, the majority of them (six of the ten managers) also expressed altruistic motives underpinning their reasons for choosing to work in the healthcare environment. However these views are not entirely surprising given that four of the six managers who expressed altruistic motives for choosing to work in a healthcare environment had a clinical background and had also previously worked in the NHS as part of their initial training (ranging from between four and twelve years) before moving to work in the private healthcare sector. The reasons for moving to work in the private healthcare

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<sup>62</sup> As shown in Appendix D.

sector were predominantly to benefit from greater career and personal developmental opportunities. All but one of the private healthcare managers interviewed in this study reported that they would repeat their decision to join to work in a healthcare environment with the benefit of hindsight of their experiences.

It is worth pointing out that whilst six of the ten private healthcare managers expressed altruistic motives underpinning their reasons for choosing to work in the healthcare environment, these sentiments had been consistently expressed more emphatically by the NHS managers during various parts of the interviews compared to those views expressed by their private sector counterparts. The findings from the interviews conducted with the private healthcare managers are interesting and despite the relatively small sample size these important observations are unique.

The findings from the present study reinforce those reported by the author previously and can also be argued to be particularly significant when considered in the context of the findings emerging from a comprehensive and large scale quantitative and qualitative based “work in progress” study conducted by Mannion et al. (2010) (and subsequently published in a summarised version by Jacobs et al. (2013)) which investigated the changing cultures, relationships and performance in the NHS.

It is worth spending some time discussing this study which is described as “the first large scale longitudinal study of culture and performance in the NHS” (ibid., p.192) and draws upon Cameron & Quinn’s (1999) “Competing Values Framework” model of organisation culture<sup>63</sup> as the main analytical framework. Mannion et al. (2010) and Jacobs et al. (2013)

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<sup>63</sup> See section 3.2.5.3 for an explanation of this model.

reported details of a three year National Institute of Health Research study based on the return of over 2000 questionnaires examining the relationship between the senior management team culture and organisational performance. It reported that although in both the Acute Care Trusts & Primary Care Trusts (PCTs) “between 2001/02 and 2006/07 ‘Clan’ remained the most dominant type of senior management team culture...its prevalence was in decline with a corresponding rise in ‘Hierarchical’ cultures...however one year later in 2007/08 (the) dominant ‘Rational’<sup>64</sup> culture had overtaken ‘Clan’ to become the most frequently reported dominant culture type. These changes were matched by corresponding falls in the frequency of “Clan” as the dominant culture...” (Mannion et al., 2010 p. 119). The study explained that the existence in the NHS of the original dominant ‘Clan’ culture indicated by senior management was unsurprising since this type of culture was characteristic of any large formal organisation such as NHS reflecting “the degree of autonomy typically associated with professional work” (ibid. p. 194). The consequent rise and predominance of the ‘Hierarchical’ culture is viewed by the authors to be due to the increasing bureaucratic nature of the NHS imposed by rules and regulations to facilitate the achievement of never ending government driven targets. The prevalence of the contemporary dominant type of ‘Rational’ managerial culture is deemed in the study to be “consistent with an NHS policy context in which pro-market developments such as the “payment-by-results hospital funding system, practice-based commission and greater involvement of private sectors providers have become increasingly prominent (within the NHS)” (ibid., p. 194).

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<sup>64</sup> The term “Rational” culture is used by the authors in their study to refer to “The Market” type of culture within Cameron & Quinn’s (1999) Competing Values Model.

Interestingly the findings relating to the GP practices surveyed in the Mannion et al.'s study (2010) were dissimilar to those associated with the Acute Care Trusts and PCTs. Within GP practices, the 'Clan' culture has remained the dominant type of managerial culture mainly due to the on-going extent of autonomy exercised by management in GP practices compared to management working in Acute Care Trusts and PCTs. This may be explained by the fact that GP practices have not yet been subjected to adopting the same extent of bureaucracy and government led targets imposed so far upon Acute Care Trusts and PCTs.

As far as the Acute Care Trusts and PCTs are concerned, the studies reported by Mannion et al. (2010) and Jacobs et al. (2013) identifies a transition in the dominant NHS senior managerial culture from a 'Clan' and 'Hierarchical' to a 'Rational' type. It could be argued that the NHS with its 'Rational' type culture and which is managed by those with a commitment to a socially responsible ethos is likely to be a desirable fusion as it may ensure that the NHS does not risk becoming divorced from its altruistic ethos as a result of the current increased marketisation of the NHS and the greater involvement of private sector providers. The findings from the study reported in this thesis regarding the NHS managers' commitment to altruistic values are therefore encouraging in this context.

Interestingly the NHS managers' perceived negative public image propagated by the NHS manager-bashing media and the politicians which is explored in the next chapter appears not to have eroded the managers' commitment to altruistic based values and neither does it appear to have diminished their overall commitment and contribution towards working in a socially responsible manner.

## **5.4 Synopsis & Concluding Remarks**

This chapter has addressed the first objective of this study which is to “identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner”. The findings demonstrate that the majority of the NHS managers interviewed in this study regardless of whether they came from a clinical or non-clinical background had wished to work in a caring based profession (such as the NHS) which had an altruistic ethos in line with their own inherent commitment towards working in a socially responsible manner. These findings are also supported and validated by those reported by the author in two earlier separate studies in 2005 and 2006. Whilst many previous studies (Blau, 1963; Mackenzie, 1995; Mellett & Marriot, 1995; Clarke & Yarrow, 1997; Young, 1999; Boyne, 2002; Exworthy et al., 2009; Granter & Hyde, 2010; Mannion et al., 2010; Jacobs et al., 2013) have also identified that public sector staff, including NHS managers, hold altruist based values, these studies have tended not to explore the relative strength of the commitment of staff to these values in any great depth. The findings from this study have attempted to address this lacunae in existing research through identifying the relative strength of the NHS managers’ commitment to altruistic based values and their commitment towards working in a socially responsible manner. Reference has also been made in this chapter to a comprehensive and large scale quantitative and qualitative case study reported by Mannion et al. (2010) and Jacobs et al. (2013) which investigated the changing cultures, relationships and performance in the NHS and concluded that there has been a transition in the dominant NHS senior managerial culture from a ‘Clan’ and ‘Hierarchical’ to a ‘Rational’ type within Acute Care Trusts and

Primary Care Trusts reflecting the evolution of a management culture which is highly competitive, market driven and goal-oriented. The findings reported in this study suggest that a deep rooted desire by NHS managers to work in a socially responsible manner would complement this changing culture.

In conjunction with the findings explored in this chapter, the next chapter addresses the second objective of this study which is “to explore the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”.

## **Chapter 6: NHS Managers & Their Perceived Public Image**

### **6.1 Summary of Chapter**

This chapter addresses the second objective of this study<sup>65</sup> which is to “explore the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”. The chapter begins by reporting the findings from the interviews conducted with healthcare managers working in the NHS followed by managers working in the private healthcare sector. These findings are subsequently explored and discussed in the context of the broader literature relating to “New Institutional Theory” as reviewed in the literature review chapter (chapter 3)<sup>66</sup>.

### **6.2 Findings**

#### **6.2.1 Findings: NHS Managers**

One of the main themes<sup>67</sup> that emerged from the analysis of the findings of this study related to the “NHS Managers & their Perceived Public Image”.

When exploring the NHS managers’ perceptions of their public image, all the ten managers interviewed universally reported that they believed the public viewed them negatively. The following representative extracts from the interviews convey the managers’ views on this subject:

*Interviewer: How do you think the public views NHS managers?*

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<sup>65</sup> As stated in section 1.3.

<sup>66</sup> See section 3.3.

<sup>67</sup> As indicated in section 4.4.1.



*"I get very irritated by it...there's a public perception that money is wasted on managers and that we sit in our offices pushing pens about and generally making lives difficult for everybody and that really we should all be sacked and all the money spent on doctors and nurses..."*

Nc8: Senior Manager, Non-clinical background.

*"I spend a lot of time in the morning shouting at Radio 4 which probably answers the question very succinctly...you know there is this idea that the public think NHS managers don't do anything..."*

C1: Senior Manager, Clinical background.

*"I think there's a media representation, this money that's gone into the health service has been spent on people in grey suits, they've added little value and I think there's a misrepresentation of managers in the health service..."*

C2: Senior Manager, Clinical background.

*"A perception that managers are not necessary and a waste of NHS funding..."*

C3: Senior Manager, Clinical background.

*"I think it has become such an easy thing to hit people with...if something's wrong within the NHS it must be the manager's fault"*

Nc5: Senior Manager, Non-clinical background.

*"There's this image of highly paid backroom managers who were adding nothing and taking money away from the hard pressed nurses..."*

Nc10: Senior Manager, Non-clinical background.

*"We are seen as faceless NHS bureaucratic managers..."*

C4: Senior Manager, Clinical background.

Four of the five managers who were involved in repeat interviews reported the same view as expressed in their earlier interview(s) (i.e. that they

believed the public continued to hold a negative view them), however interestingly one manager expressed a change in his view compared to that reported in his previous interview. Whilst in his previous interviews, as indicated in the interview extracts below, he had reported that he believed the public held a negative view of NHS managers in the latest interview he felt that there had been some improvement in the way he thought the public viewed NHS managers. He however still maintained that despite some improvement the overall public view of NHS managers remained poor.

***Interviewer: Talking about the public perception of NHS managers which is something we discussed last time we met, how do you think the public views managers within the NHS?***

*“I still think it’s incredibly negative. I don’t think it’s helped by the press at all.*

Nc9: Senior Manager, Non-clinical background (extract from 2005 interview).

***Interviewer: How do you think the public views NHS managers?***

*“I think the public perception of NHS managers is better than it was but actually it would’ve been pretty hard for it to be worse, it was vitriolic before”.*

Nc9: Senior Manager, Non-clinical background (extract from 2009 Interview).

***Interviewer: Why is it better, what’s made it better?***

*“I think a number of factors, one a change of political leadership. I think the New Labour (government), whether you supported everything they did or not, they didn’t see cutting management costs as how to deal with the NHS...I also think the waiting list targets and the eighteen week targets have delivered on the ground noticeable improvements in the NHS...”.*

Nc9: Senior Manager, Non-clinical background (extract from 2009 Interview).

When asked why the NHS managers believed that the public held a negative image of them, eight of the ten managers attributed this to the negative reporting of NHS managers in the press and media while two managers attributed this specifically to political scapegoating. The following representative extracts from the interviews relay the managers' views:

*"It's because we always have a fairly rough press".*

Nc10: Senior Manager, Non-clinical background.

*"I think because the general media are always very quick to hit (NHS) managers".*

C4: Senior Manager, Clinical background.

*"People see that whatever is printed in the papers must be true and the stories broken about NHS managers are all bad...".*

Nc5: Senior Manager, Non-clinical background.

*"The press just turn and twist everything you say, they're only interested in making the stories (about us) to be as awful as they possibly can...".*

Nc8: Senior Manager, Non-clinical background.

*"A perception that managers are not necessary and a waste of NHS funding...that's the way the media portray NHS management I think...".*

C3: Senior Manager, Clinical background.

*"I think when you listen to the radio you quite often hear that the party that's not in government has a go at the NHS and they conjure up all these figures for all the managers who they think could be taken out as presumably they think they don't do anything...".*

C1: Senior Manager, Clinical background.

*“You are working in an environment that is very exposed and very political and every so often it will suit the purposes of those who lead us to have a bash and if we make a mistake no one will defend us...”*

Nc7: Senior Manager, Non-clinical background.

When asked if the negative perceived public image of NHS managers affected them in any way half the managers irrespective of whether they came from a clinical or non-clinical background reported that they did not allow this to affect them. The following interview extracts reflect their views:

*“No it doesn’t bother me realistically because anybody who has got what it takes to come into this job or to stay in it will know before they come in the difference between the reality of politics and the reality of what’s in the press or else they can’t do the job...if you can’t work out the difference between what’s in the papers and what’s true then you certainly won’t be able to cope with the health service and the people who survive and succeed are robust...”*

Nc7: Senior Manager, Non-clinical background.

*“No it doesn’t (bother me), I think that the health service is an institution that has benefited enormously from good management”*

C2: Senior Manager, Clinical background.

*“It doesn’t bother me because I know it’s not true...”*

C3: Senior Manager, Clinical background.

*“No, it doesn’t bother me because I’m confident that on a day to day basis I add value and if anyone were to want to talk to me about that then I could demonstrate that to them...”*

Nc10: Senior Manager, Non-clinical background.

*I suspect it doesn't affect me perhaps as much as it does other managers, I think it's probably because I work with the press and I understand the sort of the drivers for some of that...".*

Nc6: Senior Manager, Non-clinical background.

On the other hand the remaining five NHS managers from both clinical and non-clinical backgrounds indicated that their negative public image did have an impact on them to varying degrees. The following interview extracts represent their views:

*"The daily (media) headlines does have an impact...(it's) quite demoralising when it's as sustained as it is...you could pretty much guarantee a negative NHS management story somewhere...".*

Nc9: Senior Manager, Non-clinical background.

*"I suppose to some degree it makes me want to kick back a bit...to help people see that there's maybe two sides to a story being portrayed...".*

Nc5: Senior Manager, Non-clinical background.

*"I suppose it does, I suppose it hits on one of my values which is about making people more aware and telling them if you like, that actually don't be so black and white about this...and perhaps educate people about what managers do in the NHS and why we are absolutely focused upon patient care...".*

C4: Senior Manager, Clinical background.

*"I feel very irritated about the manager bashing...".*

Nc8: Senior Manager, Non-clinical background.

*"I suppose I find it frustrating on behalf of the health service because of my values, I feel part of it (the NHS) and you get a sense of ownership of it...so I would probably defend it in a social setting...".*

C1: Senior Manager, Clinical background.

In summary the findings in relation to the NHS managers' views of their public image indicate that all ten of the managers interviewed universally reported that they believed the public viewed them negatively. However one manager (manager Nc9) during a repeat interview indicated a change in his view from his last interview. Although he believed there had been some improvement in the NHS managers' public perception due to some of the change in policies towards the NHS introduced by the New Labour government, overall he still maintained that the NHS managers' public image remained poor.

When asked if the NHS managers thought anything could be done to challenge their existing negative public image, the majority of the managers reported that they felt it would be very difficult, if at all possible, to successfully challenge their negative public image. This is because they believed that the press and media would not be interested in pursuing this agenda for reasons evident in the representative quotes below:

*"It's difficult to see that playing out in the national media, it's not their agenda...it is not in the interest of the national media...they like the heroes to be doctors and nurses and front line people...to suggest that kind of loyalty and dedication (from NHS managers) it's very hard to get that across..."*

Nc6: Senior manager, Non-clinical background.

*"I think that it would be of little interest, good news stories are of little interest to the media...it's not news worthy enough..."*

C3: Senior manager, Clinical background.

*"I really don't know because you know it's not what sells newspapers because newspapers are not interested in the truth. That isn't what gets people to buy them from the news-stands..."*

Nc8: Senior manager, Non-clinical background.

One of the managers, as indicated in the quote below, felt that educating the public of the actual day to day work of NHS managers and how this contributed directly or indirectly towards patient care could help challenge the NHS managers' negative public image.

*"If people could only understand what managers actually do...managers are individuals who choose to do the job they do in the main because they think its valuable and this is the contribution however obscure it might be to patient care..."*

C1: Senior manager, Clinical background.

In summary whilst all the NHS managers interviewed universally reported that they believed the public held a negative view of them, they attributed this to negative reports and stories reported in the media along with the scapegoating of NHS managers by politicians. Whilst half the managers interviewed reported that they did not allow their negative public image to affect them, the other half indicated that their negative public image did have an emotional impact upon them in different ways and to varying degrees. They were generally pessimistic with regards to the extent to which anything could be effectively done to challenge and improve their negative public image mainly because they didn't feel that it was in the media and the politicians' interests to support them in regard to this issue.

### **6.2.2 Findings: Private Healthcare Managers**

When asked what the private healthcare managers believed was the public perception of their NHS counterparts, all of them reported that they believed the public viewed NHS managers negatively. The following representative extracts from the interviews relay the managers' views:

*Interviewer: How do you think the public views NHS managers?*

*“From the press the NHS managers are constantly slated. They were given these x billion pounds in cash injection and when the NHS is still not meeting the targets then where is the money going? They’ve got all these extra management consultants in so a lot of the money is going to these people instead of what the patient wants into buying the equipment, into getting the nurses you see, so whether it’s true or not I don’t know but this is the public perception I think...”*

CC: Senior Manager, Clinical background.

*“I think the NHS managers per se have undergone a huge amount of bad press. There seems to be a public perception that within the NHS there are an awful lot of managers and an awful lot of managers working in a failing system...I think the NHS managers have a really tough time...”*

CD: Senior Manager, Clinical background.

*“The public feel that there are too many NHS managers, it’s too cumbersome and there’s too many people in offices doing stuff without being on the front line that’s what I think the public feel...”*

NcF: Senior Manager, Non-clinical background.

*“I don’t think the public view NHS managers very positively in all honesty because there’s a perception of this post-code lottery about getting your treatments, if you’re elderly you might not get the same treatment as someone else and the public will always put the managers of that organisation into that perception. That’s my understanding of that’s how the public see the NHS managers, I don’t think there’s a very positive perception”*

NcG: Senior Manager, Non-clinical background.

*I think the public view of NHS managers is generated mostly by the media...there’s the perception of the fat cat salary, lots of money sitting behind the desk”*

NcH: Middle Managers, Non-clinical background.



*“I think the public perception of NHS management is that there is probably too many of them and not enough workers such as clinical staff and I would also guess that most people blame managers for the current situation in the NHS...”*

NcI: Middle Manager, Non-clinical background.

When asked how the private healthcare managers perceived their own public image, seven of the ten managers interviewed felt that the public viewed them more positively than their NHS counterparts. The following interview extracts reflect these managers’ views:

***Interviewer: How do you think the public perceive private healthcare managers such as yourself? For example how do you think the public view you as a private healthcare manager working in the XYZ hospital (name of hospital omitted to preserve anonymity)?***

*“I think the public have a positive view of us, I would like to think that they feel the private sector has something to offer that the NHS doesn’t...”*

NcG: Senior Manager, Non-clinical background.

*“I hope they (the public) see me as someone that is keen to give them the best care I can as if it’s my next of kin, my mother or my dad or whoever”.*

CA: Middle Manager, Clinical background.

*I think the public see us as more professionally driven than in the public sector...”*

CB: Senior Manager, Clinical background.

*“I think the public feel that private healthcare managers are much more efficient than NHS managers...”*

CD: Senior Manager, Clinical background.

*“The public probably think that we’re a bit sharper than the NHS management...”*

NcI: Middle Manager, Non-clinical background.

*“As a manager here (private hospital) the public probably expect more from me, people tend to have a much higher demand and expectations in the private sector than they do of the NHS...”*

NcF: Senior Manager, Non-clinical background.

*“I think they (the public) will think that being as we are a private hospital, we are more professional”*

NcJ: Middle Manager, Non-clinical background.

The remaining three private healthcare managers as shown in the interview extracts below reported that they did not know what their public image was because they felt that unlike their NHS colleagues, issues connected to private healthcare managers were hardly reported in the press.

*“I don’t know...it’s very rare that you see private healthcare managers in the press...”*

CE: Senior Manager, Clinical background.

*“I don’t know. There doesn’t seem to be that much in the press about private healthcare, it’s sort of kept out of (ear) shot”*

NcH: Middle Managers, Non-clinical background.

*“I don’t know if the public have got a view to be honest because you don’t hear about it, not even in the press. When you have press about a private hospital it’s very rare that you ever see anything about a manager...”*

CC: Senior Manager, Clinical background.

In summary when exploring the private healthcare managers’ perceptions of their public image, none of the private healthcare managers interviewed felt that the public viewed them negatively but all reported that they

believed the public viewed their NHS counterparts poorly mainly due to negative reports about them in the media and press. Interestingly seven of the ten managers reported that they believed the public viewed them more positively than their NHS counterparts. The remaining three managers reported that they did not know what their public image was mainly because they felt that issues connected to private healthcare managers were hardly ever reported in the press.

### **6.3 Discussion**

This chapter addresses the second objective underpinning this study which is to “explore the healthcare managers’ views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS”. New Institutional Theory<sup>68</sup> as reviewed in chapter 3 is drawn upon as a valuable theoretical framework from which to explore and discuss the findings and their implications in relation to the healthcare managers’ perceived public image.

As detailed in chapter 3, proponents of New Institutional Theory locate the environment and environmental pressures as a central focus in the analysis and understanding of organisational adaptation and change (DiMaggio & Powell, 1983; Meyer & Rowan, 1991). More specifically they are concerned with exploring and understanding the macro environmental pressures which influence organisations to adapt to and conform to their environmental demands in their quest for social legitimacy (DiMaggio & Powell, 1983; Meyer & Rowan, 1991; Hirsch & Lounsbury, 1997). Social

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<sup>68</sup> See section 3.3 for the literature review relating to New Institutional Theory.

legitimacy, which is deeply valued by organisations, is explained by Hatch (1997) to be the recognition, credibility and acceptance awarded to an organisation by the environment or society in which it operates. Therefore in order to survive and prosper organisations strive to attain social legitimacy since bucking the trend of acceptance by the environment or society in which the organisation operates risks organisational demise. As Hatch (1997) starkly puts it “organisations whose environments question their right to survival can be driven out of business” (p 85).

Consequently organisations strive for this social legitimacy as much as they require a skilled labour force, investment, raw materials, etc. in order to survive and grow. In this context it is therefore not surprising that organisations tend to develop structures and processes which have been tried and tested in similar other organisations operating within the same field or business area. Hirsch & Lounsbury (1997) highlight the evidence shown whereby the more homogenous such organisations become in their field the more social legitimacy they appear to secure within their environments. In their seminal paper DiMaggio & Powell (1983) write about this as the process of “isomorphism” in which environmental pressures upon organisations result in homogeneity and conformity amongst organisations operating in the same social environment.

In relation to the process of isomorphism, DiMaggio & Powell (1983) have identified three key environmental pressures which influence organisations to conform and adapt to their environmental conditions in order to secure social legitimacy and recognition within society. The authors describe “coercive isomorphism” as the process by which an organisation faces pressure to change and conform as a consequence of governmental enforced laws and regulations. On the other hand “mimetic isomorphism”

is deemed to be the process through which an organisation copies and models the systems and structures of similar successful organisations in its field in order to deal with the pressures resulting from environmental uncertainty. Finally “normative isomorphism” is identified to be the environmental pressures that stem from the normative rules and values governing professional bodies (e.g. Chartered Management Institute, Chartered Institute of Personnel & Development, etc.) and their members. The pressures stemming from normative isomorphism usually results in professional groups largely behaving in line with the norms and values espoused by their professional bodies regardless of the nature of their differing employing organisations. The emergence of such similar behaviour by professional groups regardless of their different employing organisations is termed by DiMaggio & Powell (1983) as the “homosexual reproduction of management” and further contributes to the process of isomorphism as organisations conform and adapt to pressures from their environment so as to secure social legitimacy.

New Institutional Theory and more specifically the pressures stemming from the concept of normative isomorphism are drawn upon as a valuable framework in this chapter from which to examine the healthcare managers’ view of their public image. Also pertinent to the discussion here is the work by Meyer & Rowan, 1991 and Scheid- Cook, 1992 who have examined how professional groups consciously or unconsciously behave in a way society and the public expect them to. Furthermore Deephouse (1996, p.1025) views “public opinion...(as having)...the important role of setting and maintaining standards of acceptability (within professional groups)”. Consequently public opinion is recognised in this study to be a powerful

influencing factor upon determining acceptable standards of behaviour by professional groups including healthcare managers.

As far as the NHS managers are concerned, the findings reported in this chapter demonstrate that all the ten NHS managers interviewed in this study universally reported that they believed the public viewed them negatively. They attributed this negative public image to the widely publicised detrimental reports and stories about NHS managers reported in the media along with the regular NHS manager-bashing publicly exercised by politicians for their own instrumental agendas. These regular and unceasing attacks on managers working in the NHS appears to be relatively unique compared to the wider corporate world since as reported by Granter & Hyde (2010, p. 85) “rarely are managers denigrated in the corporate world as they are in the NHS”. Only one manager in this study believed that there had been some improvement in the NHS managers’ public perception since his last interview four years ago though he still maintained his belief that the overall public image of NHS managers remained poor. Whilst the findings in this study represent the views of only ten NHS managers, they serve to reinforce the findings of the two separate studies reported by the author in 2005 and 2006<sup>69</sup> jointly involving forty-eight face to face interviews with NHS managers working in three different London based NHS Trusts. All the NHS managers involved in those two separate studies also universally reported that they believed the public viewed them negatively.

Furthermore the NHS managers’ negative views of their public image has also been reported by other studies (Learmonth, 1997; Preston & Loan-

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<sup>69</sup> As outlined in sections 1.2.2 & 4.3.2.

Clarke, 2000; Ilett, 2011). In fact Learmonth (1997, p. 214) sums it up with a quote from an interview reported in the press with a NHS chief executive who said "people used to think we did an admirable if rather humdrum job...now they think we're all fat cats, that we drive around in BMWs, behave like the guy in Cardiac Arrest and that we just don't care". In his study Learmonth attributed the principle cause for the low public esteem of NHS managers to be the popular public view point that the traditional core values of the NHS are being violated by the efficiency seeking, cost cutting ethos of neo-Taylorist managers and he concluded "it could be that there is a commonly held view by members of the public that a service which managers are trying to make ever more efficient, rational and controlled cannot at the same time be caring and people centred" (ibid., p. 219).

Another factor contributing to the negative public image of NHS managers could be attributed to the way in which the government portrays the nature of the NHS managerial role to the public. For instance some of the government initiatives such as the "Patient's Charter" (Dept. of Health, 1992) and "Service First" (Cabinet Office, 1998) have placed managers in a prominent position for reducing costs and improving efficiency in order to reach centrally determined government targets and standards.

Consequently the public see the managers as the obstructing cost-cutting gate keepers to the provision of their healthcare and the group of people to blame when complaints arise thereby further reinforcing the public's negative view of NHS managers. The moral panic fanned by the portrayal in the popular media of NHS managers slavishly striving to meet Whitehall devised hospital targets has also reinforced the managers' negative public image. Furthermore this negative public perception of NHS managers is also fuelled by the regular NHS manager bashing carried out publically by

politicians who have regarded NHS managers as convenient scapegoats for the lack of success of the various government led reforms (Warden, 1995; Flanagan, 1997; Ham, 1997; Ilett, 2011).

With regards to the interviews conducted in this study with the private healthcare managers, the main purpose of these interviews was to explore the extent to which the issues central to the aim and objectives of this study were unique to the NHS managerial culture or whether these issues were also pertinent to private healthcare managers and therefore more widely relevant to the UK managerial healthcare sector more generally. The findings in relation to the two groups of healthcare managers involved in this study were strikingly different. Whilst all the ten private healthcare managers interviewed in this study reported that they believed that the general public held a poor image of NHS managers, seven of them interestingly reported that they believed the public held a more positive view of them compared to their NHS counterparts. The remaining three private healthcare managers reported that they did not know what their public image was mainly because they felt that (unlike their NHS colleagues) issues connected to private healthcare managers were hardly ever reported in the press. Therefore the findings of this study strongly demonstrate that the issue of the negative perceived public image of healthcare managers appears to be unique to the NHS managerial culture rather than one more widely relevant to the UK managerial healthcare sector as a whole.

The findings that NHS managers perceive their public image to be negative is not unique since numerous other studies have also confirmed this (Learmonth, 1997; Preston & Loan-Clarke, 2000; Bolton, 2003; Ilett,



2011). The study reported in this thesis however attempts to go a step further by explicitly exploring how NHS managers from both clinical and non-clinical backgrounds feel about their negative public image and explores any tensions or challenges arising therein for the NHS managers. A review of previous studies in this field reveals that the general emphasis has tended to be upon examining what and why the NHS managers believe with regards to their public image and/or upon exploring associated issues related to their managerial identity. For example Learmonth's (1997) study based on primary research involving 124 members of the public concluded that the general public held a poor image of NHS managers (though this study did not explore the implications of this for the NHS managers since NHS managers were not involved in this study).

On the other hand several other studies such as those of Bolton (2003), Kirpal, (2004) and Sambrook (2006) have focused mainly upon examining the implications of the NHS managers' negative public image in relation to issues related to the managerial identity of NHS managers who came from a clinical background. More specifically these studies have sought to explore how the managers involved in these studies made sense of their NHS managerial identity as they reconciled their clinical caring based training with their managerial cost cutting and efficiency seeking responsibilities.

There appears to be relatively scant research which directly explores how the NHS managers, from both clinical and non-clinical backgrounds feel about their negative public image and whether they experience any resultant challenges or tensions. For example Bolton's (2003) study focused exclusively upon exploring the experiences of nurse-managers (i.e.

managers with non-clinical backgrounds were not included in this study) and concluded that whilst the nurse-managers were aware of their negative public image they appeared to demonstrate the ability to reconcile their clinical and managerial roles. Similarly the author's previous study reported in 2009 was restricted to exploring the implications and impact of the healthcare managers' perceived negative public image only upon the managerial identity of those managers with a clinical background.

There are relatively few studies such as those reported by Preston & Loan-Clarke (2000) and Merali (2003), which have sought to explore the implications of the NHS managers' perceived negative public image and neither of these studies have examined the resultant tensions and challenges in adequate depth. For example Preston & Loan-Clarke (2000) interviewed thirty-nine NHS managers from non-clinical and clinical backgrounds and reported that although the managers were generally aware of their negative public image, they did not allow this to affect them. The author's previous study (Merali, 2003) reached a similar view following interviews with twenty-eight NHS managers and concluded that "despite the managers' opinion that the public perceives them to have an uncaring attitude, they themselves have not allowed this attitude to become institutionalised in their role" (p 51). While providing valuable insights into whether NHS managers had allowed their poor public image to ultimately affect their behaviours, these studies did not directly investigate in any great depth the extent to which the NHS managers' negative perceived public image had led to the managers experiencing any emotional challenges and tensions.

The study reported in this thesis contributes towards addressing this relative gap in existing knowledge by exploring in an explicit and in-depth manner the extent to which NHS managers from both clinical and non-clinical backgrounds experience and cope with tensions and challenges related to their negative perceived public image.

As outlined in the findings section of this chapter, whilst all the NHS managers interviewed in this study believed that the public viewed them negatively, interestingly half of the managers from both clinical and non-clinical backgrounds reported experiencing tensions in relation to their negative public image and believed that this had affected them either directly or indirectly to varying degrees. This finding merits further discussion and consideration particularly since a study by Scott (2002) reported that the perception of feeling valued was an important factor in the retention of effective managers within the NHS.

An analysis of the five managers who reported that their negative public image affected them showed that two of the managers came from a clinical background whereas the remaining three had non-clinical related backgrounds thereby indicating that this issue appeared to be relevant to managers in both groups (i.e. with clinical and non-clinical backgrounds). Furthermore whilst one manager (manager Nc9) indicated that he felt “demoralised” by his negative public image, two others (managers Nc5 & Nc8) felt “irritated” and wanted to “kick back” at what they claimed to be an unfair and misguided negative public perception of NHS managers. Interestingly two of the managers from clinical backgrounds (managers C1 & C4) made a specific reference to an attack upon their “values”. The nature and significance of the NHS managers’ values was explored and

discussed in detail within the last chapter<sup>70</sup> where it was reported that the majority of NHS managers interviewed in this study demonstrated an inherent commitment to altruistic based values irrespective of whether they came from a clinical or non-clinical background.

The negative emotions experienced by some of the managers as a result of their poor public image is of concern since in many cases these NHS managers had demonstrated an inherent commitment to altruistic based values which had underpinned their reasons for choosing to work in the an altruistic based environment such as the NHS in the first place. Out of the five managers (i.e. C1, C4, Nc5, Nc8 & Nc9) who reported that their negative public image affected them, four of them (C1, C4, Nc8 & Nc9) as reported in the last chapter had also demonstrated an inherent commitment to altruistic based values which underpinned their reasons for choosing to work in the NHS (only two of these managers (C1 & C4)) came from a clinical background).

The environmental pressures relating to normative isomorphism (DiMaggio & Powell, 1983) provide a useful basis from which to explore and develop insights into understanding the findings in relation to the managers who reported that that their negative public image affected them to varying extents. Normative isomorphism<sup>71</sup> highlights the influence of professional norms and values upon the behaviour of organisational actors. The key values and norms generally associated with the wider managerial profession appear to be primarily related to seeking increased

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<sup>70</sup> See section 5.3.

<sup>71</sup> Explained in section 3.3.3.

organisational effectiveness, efficiency and accountability through reducing costs and maximising profitability.

But could these values be equally expected to apply to the NHS managerial profession? On the one hand the increased emphasis placed by successive governments since the 1980s on the implementation of the New Public Management agenda<sup>72</sup> within the NHS has been to replicate the private sector business related managerial values and practices within public sector organisations such as the NHS. Public sector organisations have been encouraged to mimic their private sector counterparts in terms of becoming more efficient, effective and accountable to the government through tight cost controls. However on the other hand despite concerted efforts made by various governments over the last three decades to introduce private sector based managerial values into the NHS, the NHS managerial context remains unique as the majority of NHS managers also continue to demonstrate a uniquely strong commitment to holding altruistic based values in harmony with the altruistic ethos of the NHS (Mackenzie, 1995; Mellett & Marriot, 1995; Clarke & Yarrow, 1997; Young, 1999; 2009; Granter & Hyde, 2010, Mannion et al., 2010; Jacobs et al., 2013). It could be argued that this may be at odds with an environment driven by increased efficiency and effectiveness and preoccupied with cutting costs.

The findings reported in this study along with those reported by the author previously in 2006 suggest that this commitment to altruistic based values appears to have a solid foundation since a majority of the managers, from both clinical and non-clinical backgrounds, in both the studies had actively sought the opportunity to work in a caring based profession such as the

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<sup>72</sup> As outlined in sections 2.2.1.1.2 & 3.2.8.

NHS due to its inherent altruistic based ethos. This strong commitment to the NHS demonstrated by the majority of NHS managers interviewed in both these studies is also reinforced by the view expressed by a majority of the managers, as reported in the last chapter 5<sup>73</sup>, that given the benefit of hindsight of their experiences in the NHS, they would without hesitation repeat their decision to join to work in the NHS.

It is worth noting that although all the NHS managers in the two previous separate studies reported by the author had acknowledged their negative public image, they firmly believed this public image was misguided and driven by unfair reports in the media along with the widely publicised manager-bashing practiced by politicians for their own personal political agendas. The majority of managers in those studies reported that they had not allowed their negative public image to become institutionalised in their role. However unlike those two previous studies, the findings from the current study as discussed below revealed that half the sample of NHS managers interviewed expressed experiencing direct or indirect tensions in relation to their negative public image. The chronic incessant poor public image and on-going media manager bashing may be taking its toll on some of the NHS managers. It would therefore be useful to consider measures designed to challenge the negative public image of NHS managers so as to avoid a situation that could lead to an erosion of the currently strong inherent commitment demonstrated by a majority of the NHS managers' towards altruistic based values.

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<sup>73</sup> See section 5.2.1.

It was interesting that the majority of the managers interviewed in this study appeared not to feel optimistic about the prospects of successfully challenging their negative public image. Most of them almost automatically regarded the press and the media to be the only vehicles which could help change their image and were quick to reject the possibility of any such change as they felt it wasn't in the media or the press's interests to pursue this avenue. However on a more positive note one of the managers provided suggestions on possible ways in which the existing public image of NHS managers could be challenged through developing a more accurate public awareness of who NHS managers are, why they choose to do the job they do and their actual roles involved in developing patient care.

Encouraging greater public awareness of the values, sentiments and actual activities of NHS managers towards working in a socially responsible manner in line with the ethos of the NHS should prove fruitful in challenging the existing negative public image of NHS managers. Establishing a formal NHS policy which leads the public to becoming more aware of the NHS managers' altruistic based values and realise how their activities seek to sustain and enhance the intrinsic altruistic ethos of the NHS may challenge the public's existing negative view of NHS managers. Such a policy may also ensure that managers stay within the NHS and continue their positive contribution in line with Scott's study (2002) which found that the perception of feeling valued was an important factor in the retention of managers within the NHS. Government initiatives of involving and encouraging users of public services in determining public policy (Barnett, 2002) could also contribute towards a more educated public awareness of the valuable contribution made by NHS managers towards maintaining the NHS service ethos. Additionally NHS managers may also

need to take more personal responsibility towards challenging their negative public image through demonstrating their commitment to the NHS altruistic ethos in more caring, transparent, and overt ways. Such measures at grass roots level should contribute towards challenging the NHS managers' current negative public image and thereby cultivate a more positive public image of their role.

An improved public perception of NHS managers should contribute towards mitigating the tensions and challenges experienced by some of the NHS managers as reported and discussed in this chapter. This is likely to also have a positive impact on the NHS managers' psyche and contribute towards sustaining and enhancing their commitment to the NHS and towards continuing to work in a socially responsible manner. Such a boost to the managers' psyche would also help to ensure that such highly committed managers stay within the NHS and continue their positive contribution. This is especially relevant in view of the current recruitment and retention difficulties associated particularly with nurse-managers in the UK (Kirpal, 2004; Wise, 2007).

#### **6.4 Synopsis & Concluding Remarks**

New Institutional Theory and in particular the pressures stemming from normative isomorphism have been drawn upon as a valuable framework in this chapter to explore and discuss the findings in relation to the healthcare managers' view of their public image. Furthermore Deephouse (1996, p. 1025) views "public opinion" to be a key barometer in reflecting society's expectations when he writes "public opinion ... has the important role of



setting and maintaining standards of acceptability (within professional groups)".

The main findings as reported in this chapter demonstrated that all NHS managers interviewed in this study indicated that they believed the public viewed them negatively. They attributed this negative perceived public image to the widely publicised detrimental reports and stories related to NHS managers reported in the media along with the regular NHS manager-bashing publicly exercised by the politicians for their own instrumental agendas. This finding is supported and reinforced by those also reported by the author in two separate previous studies in 2005 and 2006 thereby increasing the validity and reliability of the current findings. Furthermore the NHS managers' negative public image has also been reported by other studies (Learmonth, 1997; Preston & Loan-Clarke, 2000, Ilett, 2011). This finding was in contrast to the views of the private healthcare managers who mainly reported that they believed the public held a more positive view of them compared to their NHS counterparts and none believed that the public viewed them negatively. On this basis it is argued that the issue related to the NHS managers' negative perceived public image appears to be an issue unique to the NHS managerial culture rather than one more widely relevant to the UK managerial healthcare sector in general.

Whilst many other studies have also reported that NHS managers universally believed that the public viewed them negatively (Learmonth, 1997; Preston & Loan-Clarke, 2000; Bolton, 2003; Ilett, 2011) there appears to be a relative lacunae in existing research exploring in any great depth and in a direct manner the extent to which the NHS managers (from both clinical and non-clinical backgrounds) experience any tensions and

challenges as a result of their negative perceived public image. This study has addressed this relative gap in the existing knowledge. Emotions of demoralisation, frustration, irritation and anger were reported by half of the managers interviewed in this study from both clinical and non-clinical backgrounds. Some of the possible measures to challenge the negative public image of NHS managers in order to mitigate these emotional tensions and challenges have been considered in this chapter. These include encouraging a greater awareness by the public of the values, sentiments and behind the scene activities of the NHS managers; NHS managers taking greater personal responsibility towards challenging their negative public image by demonstrating their commitment to the NHS altruistic ethos in a more caring, transparent, overt and public way along with initiatives involving users of public services in determining public policy. All these in combination may contribute towards a more educated public awareness of the valuable contribution made by NHS managers towards maintaining the current caring based NHS service ethos. An improved public image of NHS managers is likely to translate into a positive impact on the NHS managers' psyche and contribute towards not only sustaining, but possibly even further enhancing, their commitment to the NHS and to their socially responsible behaviour.

The next two chapters further explore some of the implications of the issues raised in this chapter in relation to the NHS managers' work and self-identities (chapter 7) and the extent to which the NHS's CSR strategy reflects the NHS managers' commitment towards working in a socially responsible manner (chapter 8).

## Chapter 7: NHS Managers' Self & Work Identity

### 7.1 Summary of Chapter

In relation to the overall aim of this study, this chapter focuses upon addressing the third objective of this study which is to “explore the healthcare managers’ self and work identities”. The findings related to this objective are identified and discussed in this chapter through drawing upon the relevant literature and theoretical frameworks related to Self and Work Identity Theory as reviewed in the literature review chapter (chapter 3)<sup>74</sup>.

### 7.2 Findings

#### 7.2.1 Findings: NHS Managers

A key theme<sup>75</sup> that emerged from the analysis of the primary research interviews related to the “NHS managers’ Self and Work Identity”.

As shown in Appendix D, of the ten NHS managers interviewed in this study, four had a clinical background whilst the remaining six managers came from a non-clinical background. When exploring how the managers from a non-clinical background felt about their identity in relation to their formal occupational title of an “NHS manager”, the following representative extracts from the interviews convey the managers’ feelings on the subject:

*Interviewer: If I met you for example for the first time as a stranger at a party and asked you what you do in your job, what would you say?*

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<sup>74</sup> See section 3.4.

<sup>75</sup> As indicated in section 4.4.1.

Not surprisingly each of the six NHS managers with a non-clinical background indicated in the interviews that they would usually introduce themselves to a stranger by their managerial title. The quote below represents this general finding:

*“I’d usually say I’m a director or a manager in the NHS”.*

Nc10: Senior Manager, Non-clinical background.

Interestingly however one of these six managers with a non-clinical background as shown in the interview extract below appeared to be somewhat defensive about introducing himself as a manager working in the NHS. He only appeared to be willing to reveal his managerial title to a stranger when pressed to do so:

*“I’d say I’m in healthcare or I work for the NHS and then most people would say “are you a doctor or a nurse?” and I’d say “no I’m not clinical” and they’d say “well what are you?” and I’d say “I’m a manager” and then wait for the political lecture from the front pages of the Daily Mail”.*

Nc9: Senior Manager, Non-clinical background.

The findings from the interviews with the four managers who had a clinical background were particularly interesting. Whilst one of the managers was candid about introducing herself by her managerial title, two appeared to be defensive and one appeared to feel so uncomfortable that she indicated that she would conceal her managerial title when introducing herself to strangers at a party. The following extracts represent these varied views.

The interview extract relating to the manager who was candid about her managerial title is shown below:

*“I’d probably say I’m a director in the NHS...”*

C3: Senior Manager, Clinical background.

On the other hand the following interview extracts represent the sentiments of the two managers who appeared to be more defensive about revealing their managerial title:

*“I would say I was involved in project management and change in the NHS. If somebody pushed me and says are you one of those faceless bureaucratic managers I wouldn’t deny it but I’d say this is what I do and this is how it makes a direct difference to patient care...”*

C4: Senior Manager, Clinical background.

*“I’d probably say I work (gives the name of the NHS Trust) and people would usually say are you a nurse and I usually say “no, I used to be (gives specialist clinical title) but now I work in capital planning.*

C1: Senior Manager, Clinical background.

The reasons provided by both the managers (i.e. managers C4 & C1) identified above for their defensiveness as already hinted at in the first of the two quotes above was made even more bluntly in the interview extract from one of the interviews shown below:

*“I find it frustrating because of my values...I think the press and for the purposes of some of the other political parties it suits them to have this idea that there is all these managers twiddling their thumbs and wasting money”.*

C1: Senior Manager, Clinical background.

The next interview extract represents the view of the single manager who indicated that she would conceal her managerial title:

*“I’d introduce myself as a midwife”.*

C2: Senior Manager, Clinical background.

When exploring why manager C2 would conceal her managerial title, the following interview extract provides interesting insights into her reasons:

***Interviewer: That’s interesting, could you tell me why you’d introduce yourself as a midwife rather than a manager when only 20% of your time is spent as a midwife and you are a senior manager, a director in the NHS? Why not introduce yourself by your managerial position which reflects the majority of your role?”.***

*“I’d say I’m a midwife...I suppose it depends on how much I want to impress”.*

C2: Senior Manager, Clinical background.

In summary when exploring how the ten NHS managers interviewed in this study felt about their identity in relation to their formal occupational title of an “NHS manager”, the findings revealed in a few cases that there was a tendency for the NHS managers from both clinical and non-clinical background to be either defensive about their managerial title or in one case to conceal this title altogether. As far as the four NHS managers with a clinical background were concerned, although they all performed exclusively or predominantly managerial functions with either very little or no clinical duties, only one manager was candid about introducing herself by her managerial title to a stranger at a party. On the other hand two of them appeared to be defensive about their managerial titles when making introductions to a stranger. The reason for this defensiveness appeared to be because they felt the public viewed them negatively. The remaining manager appeared to conceal her managerial title and instead stated she

would introduce herself by her clinical background (despite performing a predominantly managerial role with only 20% of her time spent on clinical duties). She believed the public would be more impressed by her clinical role rather than her managerial one. As far as the six managers with a non-clinical background were concerned, whilst unsurprisingly they all indicated that they would introduce themselves to a stranger by their managerial title one of these managers (manager Nc9) appeared to be defensive about owning up to his managerial title because he felt the public viewed NHS managers negatively.

### **7.2.2 Findings: Private Healthcare Managers**

Interesting findings emerged when exploring how the private healthcare managers from both non clinical and clinical backgrounds would introduce themselves to strangers at a party in relation to their identity as a healthcare “manager”. As far as the private healthcare managers with a non-clinical background were concerned, all five of these managers were candid about their managerial title and indicated that they would be happy to introduce themselves to strangers by their managerial titles. The following three representative extracts from the interviews depict these sentiments:

*“I’d say I’m the deputy manager of the (gives department name).”*

NcH: Middle Manager, Non-clinical background.

*“I would say I work as a manager for a part of the hospital”.*

NcF: Senior Manager, Non-clinical background.

*“I would say I work at the (gives name of private hospital) and I’m the (gives formal managerial title)...I’m very proud of what I do”.*

NcG: Senior Manager, Non-clinical background.

In contrast, as far as the five private healthcare managers with a clinical background were concerned, whilst one manager indicated he would introduce himself by his managerial title (though he appeared to be somewhat defensive about this) the remaining four managers appeared to conceal their managerial titles and indicated that they would introduce themselves to a stranger at a party by their clinical backgrounds (despite performing either exclusively or predominantly managerial functions in their day to day activities). The following interview extracts represent these managers' views along with the reasons they provided for them.

*"The first thing I say is that I work in an operating theatre, then depending on what the next question is usually some people will say "oh that's interesting, what do you do?" and I will then say I'm the manager there..."*

CC: Senior Manager, Clinical-background.

When probed in the interview as to why he appeared to be defensive about his managerial title, he gave the following explanation:

*"I didn't ask for a managerial title and I enjoy my clinical duties..."*

CC: Senior Manager, Clinical-background.

The following interview extracts relate to those four managers who appeared to conceal their managerial titles and instead preferred to introduce themselves to a stranger at a party by their clinical titles. The reasons given by each of the managers for this are provided in the interview extracts below:

*"I would say I'm a nurse..."*

CB: Senior Manager, Clinical-background.



***Interviewer: “That’s interesting because 80% of your duties are managerial rather than clinical, so what is the reason why you would introduce yourself as a nurse as opposed to a senior manager?”.***

*“Part of the reason would be that I’m trying to kind of enhance and kind of improve the picture...make it more professional I guess”.*

CB: Senior Manager, Clinical-background.

*“I love being a (gives specialist clinical title) and that’s what I’d say...”.*

CD: Senior Manager, Clinical-background.

***Interviewer: “What is interesting is that you would introduce yourself in a role that is very much a clinical role yet at the moment you tend to perform most of your duties in a managerial position, why then would you introduce yourself by your clinical background?”.***

*“I certainly feel that if I didn’t have my clinical experience I would not be able to offer what I do as a manager...also when you say the word “manager” it’s relatively generic and I don’t necessarily think the word “manager” necessarily defines me”.*

CD: Senior Manager, Clinical-background.

Similarly the interview extract relating to the following two managers also demonstrate the managers concealing their managerial identity in favour of their clinical role when introducing themselves to a stranger:

*“I’d say I’m a nurse with add on skills”.*

CE: Senior Manager, Clinical-background.

*“I would say to you that I’m a (gives specialist clinical title)”.*

CA: Middle Manager, Clinical-background.

When asked why the two managers would introduce themselves by their clinical titles, they provided the following comments:

***Interviewer: Why is that since it doesn't reflect the day to day reality of your work as you are performing in an exclusively managerial position with no clinical duties?"***

*"It doesn't, you're quite right... I want to show I understand the clinical side which is why management takes a second seat".*

CA: Middle Manager, Clinical-background.

*"Because I see the managerial role more as an add-on".*

CE: Senior Manager, Clinical-background.

In summary the findings from the interviews with private healthcare managers from both clinical and non-clinical backgrounds relating to how they felt about their identity as a "healthcare" manager revealed that all five of the private healthcare managers from a non-clinical background appeared to be candid about their managerial title when introducing themselves to strangers at a party. In contrast as far as the private healthcare managers with a clinical background were concerned whilst one manager (manager CC) indicated he would introduce himself by his managerial title (though he appeared to be defensive about this), the remaining four managers (managers CA, CB, CD & CE) appeared to conceal their managerial titles and instead preferred to introduce themselves to strangers at a party by their clinical backgrounds. The two main reasons provided for the managers' responses were either due to a belief that the public viewed clinical occupational roles in higher esteem than managerial roles and/or that the managers appeared to personally identify more strongly with their clinical occupational backgrounds and

identities despite performing predominantly or exclusively managerial functions.

The next section provides a discussion of these findings through drawing upon relevant theoretical frameworks related to Self and Work Identity Theory.

### **7.3 Discussion**

The central focus in this chapter is to address the third objective of this study which is to “explore the healthcare managers’ self and work identities”. This is considered to be important since how managers perceive their self and work identities and how they are perceived by others has implications for their work performance, commitment and satisfaction (Kirpal, 2004; Blenkinsopp & Stalker, 2004). Self and Work Identity Theory<sup>76</sup> is drawn upon in this chapter as the main theoretical framework from which to explore and discuss the findings related to the primary research undertaken in this study.

As outlined in the literature review chapter (chapter 3), the study of individual identity is of significance to a wide range of disciplines since as articulated lucidly by Linstead et al. (2009) “we all need to ask, and know, who am I? When we enter the world, the process of finding the answer is essential to our becoming fully developed individuals” (p. 448). Furthermore Cerulo (1997) highlights the implications for understanding individual identity in relation to individual agency when he explains that seeking to answer the question “who am I” has implications for understanding “how should I act?”. Although the study of the concept of

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<sup>76</sup> See section 3.4 for the literature review relating to Self and Work Identity Theory.

individual identity has been long established in a number of academic disciplines such as Philosophy, Anthropology, Sociology and Psychology it has only relatively recently gained increasing prominence in the field of Organisation Studies. This is attributed mainly to the increasing significance of the world of work to the lives of individuals in the 21<sup>st</sup> century (Fineman, 1983; Linstead et al., 2009). Fineman goes further in emphasising the increasing influence of the role of the world of work upon shaping individual identity when he writes that the world of work has become the “defining aspects of personal status and identity” (1983, p. 148).

The stance taken towards research of individual identity by organisation scholars has been inevitably influenced by their adopted ontological and epistemological positions. For instance as outlined in the literature review chapter<sup>77</sup> scholars leaning towards the Functionalist perspective tend to explore, examine and understand individual identity with a predilection for instrumental objectives viz-a-viz seeking improved organisational efficiency and effectiveness whilst those developing an Interpretivist approach appear to focus more on the study of individual and work identity so as to develop insights into issues related to how individuals construct and re-construct their identities and give meaning to this through their interaction with others.

In this context individual identity is seen to be dynamic and emergent in nature (Watson, 1994). As Alvesson et al. (2008) highlight “for interpretively inclined organizational researchers, identity holds a vital key to understanding, the complex, unfolding and dynamic relationship between self, work and organization” (p. 9). On the other hand scholars

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<sup>77</sup> See section 3.4.3.

who ally themselves with the critical school of thought tend to focus upon the study of individual identity mainly in the context of understanding the influence of the dynamics of power, control and resistance within organisations and the wider society and their influences upon the construction and re-construction of individual identity. Consequently this increasing popularity of the study of self and work identity within Organisation Studies has led to the development, use and application of a wide range of theories, models and approaches dedicated to exploring and developing rich insights into this field. In the main these include: Social Identity Theory (SIT), the Psychoanalytical, Foucauldian, Symbolic Interactionist and Narrative based approaches<sup>78</sup>.

As already discussed in the Methodology<sup>79</sup> chapter the author has adopted a predominantly interpretivist approach towards exploring and understanding the issues related to the healthcare managers' self and work identities. This approach is in harmony with the overall ontological and epistemological position adopted in this study and provides an appropriate framework to explore and develop insights into understanding how the healthcare managers construct and reconstruct their self and work identities and give meaning to this through their interactions with others. In this context it would be useful at this stage to emphasise the distinction between "Self" and "Work" identity. According to Walsh & Gordon (2008 p. 47) work identity is seen as "a work-based self-concept, constituted of a combination of organizational, occupational, and other identities that shapes the role a person adopts and the corresponding ways he or she behaves when performing his or her work".

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<sup>78</sup> As explained in sections 3.4.3.1-3.4.3.5 (incl.).

<sup>79</sup> See section 4.2.5.

As the world of work increases its prominence in the lives of individuals in the 21<sup>st</sup> century, work identity has become an increasingly more central facet to an individual's self-identity. This point is emphasized by French et al. (2011) when they write "the notion of identity (who am I?) is intimately tied to the meaningfulness of one's job" (p. 379). Within this context, Alvesson & Willmott's (2002) theoretical framework, which highlights the complex interrelationship between three key influencing factors namely "self-identity", identity regulation" and "identity work"<sup>80</sup> is drawn upon to provide a valuable overarching framework from which to explore and discuss the main findings reported earlier in this chapter. This framework provides a useful basis from which to understand and make sense of the main findings of this study so as to develop key insights into the issues connected to the self and work identities of those healthcare managers who participated in this study.

With regards to the primary research interviews conducted with the NHS managers who participated in this study, the findings related to the interviews with the four NHS managers from a clinical background revealed particularly interesting insights into how these managers felt about their "NHS managerial" identities. Although these NHS managers performed exclusively or predominantly managerial functions with either very little or no clinical duties, only one manager (C3) was candid about introducing herself by her managerial title to a stranger at a party. The other two managers (C1 & C4) appeared to be defensive about their managerial titles whilst one manager (C2) went as far as to indicate that she would conceal her managerial title and would instead introduce herself by her clinical background. Two of these managers (C1 & C2) who were

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<sup>80</sup> See section 3.4.4 for an explanation of Alvesson & Willmott's (2002) theoretical framework.

repeat interviewees following their involvement in a previous research study reported by the author in 2009 had indicated identical views in their previous interviews related to this issue. As far as the NHS managers with a non-clinical background were concerned, although unsurprisingly all six of them indicated they would introduce themselves to a stranger at a party by their managerial titles (since unlike their clinical colleagues these managers did not have any other choice) as indicated in the last chapter<sup>81</sup> three managers with a non-clinical background (managers Nc5, Nc8 & Nc9) expressed that their negative public image did have a detrimental impact on them. However one of these managers (Nc9), as indicated in the findings of this chapter, appeared to be particularly defensive in that he only appeared to be willing to reveal his managerial title to a stranger when pressed to do so. Although manager Nc9 was also a repeat interviewee, this was a novel insight since in the previous study reported by the author in 2009 it had been naively assumed that all managers from a non-clinical background would be candid about introducing themselves by their managerial titles to strangers at a party and therefore this issue was not explored in that study.

As Alvesson & Willmott's theoretical framework (2002) which highlights the complex interrelationship between three key influencing factors namely "self-identity", identity regulation" and "identity work" provides a valuable basis from which to explore and understand these findings, it would therefore be useful at this stage to briefly revisit these three key influencing factors<sup>82</sup>. Whilst "self-identity" is seen by Alvesson & Willmott (2002) to reflect the core essence of the individual's identity in terms of addressing the question "who am I?", the concept of "self-identity" appears to be

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<sup>81</sup> See section 6.2.1.

<sup>82</sup> See section 3.4.4 for an explanation of Alvesson & Willmott's (2002) theoretical framework.

highly complex since as succinctly put by McKenna (2010) “identity construction is not undertaken in a vacuum...rather it is undertaken dialogically, in context with other people, within organizations and in society” (p. 6). The complexity of this process is further compounded by the recognition that identity formation is not only influenced by the interactions between the person and other individuals but furthermore “identity is formed in response to what a person might be expected to be defined by the structures, context and discourses within which they operate” (McKenna, 2010, p. 6). Therefore the dominant structures and discourses prevalent within organisations and the broader society which constitute “identity regulation” also influence the construction and re-construction of the individual’s self-identity through the process of “identity work”. Alvesson et al. (2008, p. 15) define identity work as “the ongoing mental activity that an individual undertakes in constructing and understanding of self that is coherent, distinct and positively valued”. The process of identity work is therefore regarded to be the main sense making interpretive process which influences the formation and reformation of the individual’s self-identity.

The findings as reported earlier in this chapter relating to the three managers from a clinical background (managers C1, C2 & C4) and the one manager from a non-clinical background (manager Nc9) could therefore be interpreted to demonstrate inherent tensions as far as these managers’ identity work is concerned given that they were either defensive or actively concealing their managerial title when introducing themselves to a stranger at a party. The underlying reasons provided by these four managers for concealing or being defensive about their managerial titles provides a deeper and interesting insight into understanding the causes of these



inherent tensions which appear to be related to issues connected to identity regulation within Alvesson & Willmott's model (2002). The three NHS managers (i.e. two with a clinical background (C1 & C4) and one who came from a non-clinical background (i.e. manager Nc9)) who were defensive about their managerial titles when introducing themselves to a stranger at a party attributed the main reason for their defensiveness to be due to their view that the public hold a negative image of NHS managers.

This insight is even more interesting when considered in the context relating to these managers' mainly altruistic reasons for choosing to join to work in the NHS as reported and discussed in chapter 5<sup>83</sup>. Hence the findings relating to these three NHS managers suggest tensions in these managers' identity work as a result of issues connected to identity regulation such as the on-going prevalence of a dominant negative NHS managerial discourse. Furthermore as shown in chapter 6<sup>84</sup>, two other managers with a non-clinical background (managers Nc5 & Nc8) had also expressed that their negative public image did have a detrimental impact on them though they did not go as far as to be defensive about their managerial title (like manager Nc9) when introducing themselves to a stranger. This negative discourse as discussed in the last chapter<sup>85</sup> appears to be fuelled by popular NHS manager bashing stories publicised by the media and propagated by politicians for personal expediencies.

Interestingly a different insight appears to be evident in relation to interview finding as outlined earlier in this chapter relating to the manager from a clinical background (manager C2) who appeared to go as far as to conceal her managerial title and would instead introduce herself by her

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<sup>83</sup> As reported and discussed in sections 5.2.1 & 5.3.

<sup>84</sup> See section 6.2.1.

<sup>85</sup> See section 6.3.

clinical background when introducing herself to a stranger at a party despite performing relatively negligible clinical duties. Although as reported in chapter 6<sup>86</sup>, this NHS manager (like the rest of the NHS managers interviewed in this study) believed that the public viewed NHS managers negatively, however this did not appear to be the main reason why she appeared to conceal her managerial title. She attributed her reason for introducing herself by her clinical background to a stranger at a party so as to “impress” others with her clinical title. This suggests that she perceived society to view a clinical title in higher esteem than a managerial title. Interestingly this manager (manager C2), unlike the other three managers (managers C1, C4 and Nc9), had not chosen to actively work in the NHS due to altruistic motives but as reported in chapter 5<sup>87</sup> had indicated that she “fell into nursing”. Consequently drawing on Alvesson & Willmott’s theoretical model (2002), it could be argued that although this manager also experienced tensions in her identity work as far as her managerial title was concerned, this was not necessarily due to the negative public image she attributed to NHS managers but instead it appeared to be due to the prestige she believed society associated with clinical roles compared to managerial positions.

These insights into identifying underlying tensions related to the identity work of the NHS managers from both clinical and non-clinical backgrounds as a consequence of factors connected to identity regulation are relatively unique when considered in the context of the wider existing literature in this field. There have been a number of studies undertaken over the last two decades focused upon developing insights into exploring and understanding issues connected to the self and work identity of NHS

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<sup>86</sup> See section 6.2.1.

<sup>87</sup> See section 5.2.1.

managers (Forbes & Prime 1999, Bolton, 2003; Hallam, 2002; Kirpal, 2004; Sambrook, 2006; Wise, 2007; Ilett, 2011; Hyde et al., 2012) however the majority of these studies have been mainly preoccupied with examining issues of the NHS managerial identity in relation to how clinical professionals such as doctors and nurses have adjusted to transitions from a clinical role to a predominantly or exclusively managerial role within the NHS as a result of career progression and/or personal development training. Whilst some studies have identified tensions in the work identities of nurses and nurse managers as they attempt to reconcile their clinical and managerial roles (Kirpal, 2004; Wise, 2007; Hallam, 2002; Bolton, 2003) other studies have reported cases where, with some exceptions, nurses and radiographers have adopted managerial roles without experiencing any difficulty in their emergent coexisting managerial and professional identities (Sambrook, 2006; Forbes & Prime, 1999).

A relatively few studies (Merali, 2009; Ilett, 2011; Hyde et al., 2012) appear to have focused directly upon exploring issues related to the NHS managers' perceived public image and the implications of this upon the NHS managers' self and work identities. For instance a separate study reported by the author in 2009 sought to "identify and explore tensions and challenges experienced by NHS managers while working for a socially responsible organization and the implications this had for the (re)formation of their work and self identities" (Merali, 2009, p. 152). Although this study provided useful insights into issues related to the work identities and experiences of the NHS managers in relation to the managers' negative perceived public image, it was exclusively occupied with exploring issues affecting only those managers who came from a clinical background. Furthermore whilst Ilett's study (2011) provides a useful insight into the

wide range of issues affecting the self and work identity of senior NHS managers working in Scotland (such as the extent of their affiliation to the NHS, the transition of managers working in a clinical role to a predominantly non-clinical managerial role and the effect of the negative media image on their managerial identities), the exploration of such a wide range of issues in that study restricted an in-depth approach to the examination of the impact and implications of the tensions specifically related to the managers' negative public image on their identity work.

Similarly a study by Hyde et al. (2012) provided an interesting examination of issues related to "how middle managers defined their work identities and how their work identities were constructed around them with consequent implications for the organisation of work" (p. 8). Hyde et al.'s study (ibid.) also developed useful insights into the extent of tensions being experienced in the identity work of NHS middle managers as a result of widespread negative appraisals of middle managers in the popular and academic press resulting in "leaving middle management as an identity no one wants".

Although Hyde et al.'s study (ibid.) developed valuable insights into these issues it was relatively limited in scope since it was focused exclusively upon examining issues connected to the identity of those NHS managers who occupied middle management positions. Whilst such studies have generated useful insights into the wide range of issues related to the construction and re-construction of NHS managers' work identities, the issues specifically connected to the managers' perceived public image and its impact on the manager's self and work identity have not been researched in any depth and the area has generally remained relatively neglected.

As far as the findings related to how private healthcare managers from clinical and non-clinical backgrounds felt about their managerial identities is concerned, there appeared to be an interesting difference between these two groups of managers. As reported earlier in this chapter, whilst all five of the private healthcare managers from a non-clinical background appeared to be candid about their managerial title when introducing themselves to a stranger at a party, surprisingly four of the five managers from a clinical background (i.e. managers CA, CB, CD & CE)<sup>88</sup>, who despite performing either exclusively or predominantly managerial functions on a day to day basis, indicated that they would conceal their managerial titles and would instead introduce themselves to the stranger at a party by their clinical titles. The remaining manager with a clinical background (manager CC) appeared to be defensive about introducing himself by his managerial title to a stranger.

The underlying reasons, provided by these five private healthcare managers with clinical backgrounds for either concealing or being defensive about their managerial titles when introducing themselves to a stranger provides a deeper and interesting insight into the factors contributing to the inherent tensions in their identity work. As far as manager CB was concerned, his main reason for concealing his managerial identity and instead projecting his clinical role was because he felt a clinical role was perceived by others in society to be more impressive and held in higher professional esteem than a managerial role. On the other hand the main reason why managers CD and CC appeared to conceal their managerial title and instead projected their clinical roles was because they appeared to identify particularly strongly with their clinical professional identities and felt the clinical title

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<sup>88</sup> As reported in section 7.2.2.

more accurately and inherently defined who they were. Similarly manager CE also appeared to feel more strongly connected to his clinical based professional identity and regarded his managerial role as more of an “add-on” function to his clinical role despite performing predominantly managerial functions on a day to day basis.

Likewise although manager CA performed predominantly managerial functions, she preferred to project her clinical based title because she felt this resonated more with her clinical background and the identity which she felt strongly connected to. These findings suggest tensions evident in the identity work of these managers which appeared to be attributed to different factors. The tensions in the identity work relating to manager CB appeared to be similar to the case of manager C2 who worked in the NHS (as discussed earlier) as they stemmed from a view that a clinical role was perceived by others in society to be more professional and held in higher esteem than a managerial role.

The tensions evident in the identity work of the other four managers with a clinical background (managers CA, CC, CD & CE) were attributable to other reasons. These managers appeared to experience tensions in their identity work because they identified particularly strongly with their clinical professional identities as they felt that this inherently defined who they were. This is also reinforced by the earlier findings as reported and discussed in chapter 5<sup>89</sup> in which it can be seen that three of these four managers (managers CA CB & CD) had reported altruistic motives underpinning their reasons for seeking to work in a private healthcare environment thereby demonstrating a strong inherent commitment to their chosen clinical profession. Only manager CE had indicated that he had not

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<sup>89</sup> See section 5.2.2.

specifically “chosen” to work in healthcare but had “joined healthcare by accident”<sup>90</sup> yet as reported earlier in this chapter he too demonstrated a strong connection to his clinical professional identity.

It would be useful at this stage to discuss the distinction between “managerial” and “professional” identities. McKenna (2010, p. 5) views “managerial identity (to be) partly a product of dominant discursive/ideological formation rather than individual choice...managers assume a managerial identity that reflects current dominant discourse about what a manager should be”. From this perspective it could be argued that factors external to the individual such as the prevailing managerial discourses in society are deemed to be central in influencing and shaping the individual’s self and work identity.

This point is underlined by McKenna (2010) who states “the social construction of identities is subject to influences outside of the individual” (ibid., p. 6). Professional identity on the other hand is associated with the consideration of the question “who am I?” in relation to the strength of allegiance that individuals develop to their professional bodies such as for instance those affiliated to Accountancy, Medicine and Law (McAuley et al., 2007). As Kirkpatrick et al. (2005) articulate, members of a profession tend to be highly defensive in safeguarding and justifying their reputed and privileged positions.

The findings as reported earlier in this chapter related to the interviews with four private healthcare managers from a clinical background (managers CA, CC, CD & CE) suggest that these managers appear to experience tensions in their identity work mainly because they appear to

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<sup>90</sup> As reported in section 5.2.2.

identify particularly strongly with their clinical professional roles (rather than a managerial identity) which they felt inherently defined who they were. Drawing on Alvesson & Willmott's (2002) model it could be argued that the strength of this connection to their professional clinical role comprises a key factor within the identity regulation dimension of the model responsible for causing tensions in these managers' identity work.

A comparison of the findings between the NHS managers and private healthcare managers interviewed also provides interesting insights into issues related to managerial identity which appear to be both unique to the NHS managerial culture and more widely applicable to both the public and private healthcare environments. When comparing the tensions identified in the identity work of the NHS managers with those of the private healthcare managers, it appears that the NHS managers are unique in so far as any tensions reported by them tend mainly to result from their view that the public holds a negative image of them.

On the other hand there appear to be different underlying reasons responsible for causing tensions in the identity work of some private healthcare managers. This mainly appeared to be because these managers identified particularly strongly with their clinical professional identities which they felt inherently defined who they were. Furthermore another common factor responsible for causing tensions in the identity work of one NHS manager (manager C2) and one private healthcare manager (manager CB) who had both indicated that they would introduce themselves by their clinical backgrounds rather than their managerial titles was related to the perception that the public viewed clinical roles to be more professional and prestigious compared to managerial roles and therefore held in higher esteem.



Hence drawing on Alvesson & Willmott's (2002) theoretical model, it could be argued that tensions related to the managerial identity of the healthcare workers who participated in this study can be attributed to a multitude of factors related to identity regulation. As far as the NHS managers are concerned, this mainly relates to the prevalence of a dominant negative NHS managerial discourse perpetuated by politicians and the media. A common factor causing tensions in the identity work of both NHS and private healthcare managers stemming from identity regulation appears to be the prestige that the healthcare managers believe is attributed to the clinical profession by society. In the case of the private healthcare managers from a clinical background the tensions evident in their identity work appear to be attributed to the strong sense of identity these managers appear to have developed to their clinical professional roles which they felt inherently defined who they were. This could be attributed not only to the strength of the managers' personal altruistic based values but also to aspects connected to identity regulation in relation to the norms and values cultivated and promoted through discourses associated with professional bodies in the wider clinical professions.

#### **7.4 Synopsis & Concluding Remarks**

The central focus in this chapter has been to address the third objective of this study which is to "explore the healthcare managers' self and work identities". This is considered to be significant since how managers perceive their self and work identities and how they are perceived by others has implications for their work performance, commitment and satisfaction (Kirpal, 2004; Blenkinsopp & Stalker, 2004).

Through drawing on relevant literature related to Self and Work Identity the author has adopted a predominantly interpretivist approach towards exploring and understanding the issues related to the healthcare managers' self and work identities since this approach is in harmony with the ontological and epistemological position adopted in this study<sup>91</sup>.

Alvesson & Willmott's (2002) theoretical framework, which highlights the complex interrelationship between three key influencing factors namely "self-identity", identity regulation" and "identity work"<sup>92</sup> is specifically drawn upon in this chapter to provide an overarching framework from which to explore and discuss the main findings reported at the beginning of this chapter. This framework has proved invaluable in terms of understanding and making sense of the main findings of this study so as to develop insights into the issues connected to the self and work identities related to the healthcare managers involved in this study.

The insights connected to the healthcare managers' self and work identities were developed in relation to exploring how both groups of managers (i.e. those working in the NHS and private healthcare) from clinical and non-clinical backgrounds would introduce themselves to a stranger at a party. Furthermore their responses to this issue was cross related to other relevant issues explored in the interviews (such as their reasons for joining the NHS as discussed in chapter 5 and their views of their public image as discussed in chapter 6). This allowed the development of a more holistic approach to the understanding of the issues connected to their self and work identities.

A comparison of the interview findings between the NHS and private healthcare managers provided interesting insights into issues related to

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<sup>91</sup> See section 4.2.5 for a rationale of the methodological position adopted in this study.

<sup>92</sup> See section 3.4.4 for an explanation of Alvesson & Willmott's (2002) theoretical framework.

managerial identity which appear to be both unique to the NHS managerial culture and also more widely relevant to both the public and private managerial healthcare environments. Drawing on Alvesson & Willmott's framework (2002), it could be argued that tensions identified in relation to the managerial identity of the healthcare workers who participated in this study can be attributed to a multitude of factors related to identity regulation. As far as the NHS managers are concerned, this mainly relates to the prevalence of a dominant negative NHS managerial discourse perpetuated by politicians and the media. However a common factor attributed to causing tensions in the identity work of both NHS and private healthcare managers appears to be the prestige that the healthcare managers with clinical backgrounds believe is attributed to the clinical profession by society. In the case of the private healthcare managers with a clinical background, the tensions evident in their identity work appear to be attributed to the strong sense of identity these managers appear to have developed to their clinical professional roles which they felt inherently defined who they were. This could be attributed not only to the strength of the managers' personal altruistic based values but also to aspects connected to identity regulation in relation to the norms and values cultivated and promoted through discourses associated with professional bodies in the wider clinical professions.

These insights into identifying underlying tensions related to the identity work of the healthcare managers from both clinical and non-clinical backgrounds as a consequence of factors connected to identity regulation are relatively unique to the study reported in this thesis and leads to a greater understanding of issues associated with the self and work identity of healthcare managers. The discussion in this chapter provided a resume of

the existing relevant literature in this field along with a commentary on its merits and omissions. From this it is evident that whilst existing studies have generated deep and rich insights into a wide range of issues related to the construction and re-construction of NHS managers' work identities, the extent and depth of the exploration of these issues specifically connected to the managers' perceived public image and its impact on the manager's self and work identity has remained relatively unexplored. The study reported in this thesis has sought to address this relative gap in knowledge by discussing the findings and drawing on Alvesson & Willmott's (2002) theoretical framework to develop insights into understanding and exploring the tensions experienced by some of the NHS managers as a direct result of their negative perceived public image and its effects on the NHS managers' self and work identities.

The next chapter explores and identifies ways in which some of the issues related to the tensions identified in the NHS managers' work and self identities connected to their negative perceived public image could be effectively addressed.

## **Chapter 8: NHS Managers & Social Responsibility**

### **8.1 Summary of Chapter**

In line with the overall aim of this study the central focus of this chapter is to address the final objective of this study which is “to critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers”. Relevant literature related to CSR and Social Responsibility as reviewed in the literature review chapter (chapter 3)<sup>93</sup> is drawn upon in this chapter to explore and discuss the main findings emerging from the primary research interviews related to this objective.

### **8.2 Findings**

#### **8.2.1 Findings: NHS managers**

The final theme<sup>94</sup> that emerged during the analysis of the findings of this study related to “NHS Managers and Social Responsibility”.

As discussed in chapter 5<sup>95</sup> whilst the majority of the NHS managers interviewed in this study demonstrated an inherent commitment to altruistic based values and toward behaving in a socially responsible manner, all ten of the NHS managers as reported in chapter 6<sup>96</sup> universally believed the public did not recognise this commitment and in fact held a negative image of NHS managers. When exploring how this negative public image could be challenged, the NHS managers were asked whether they felt that having

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<sup>93</sup> See section 3.5.

<sup>94</sup> As indicated in section 4.4.1.

<sup>95</sup> See section 5.3.

<sup>96</sup> See section 6.2.1.

an explicit statement relating to their commitment towards working in a socially responsible manner included within the NHS's publicised CSR strategy would go some way towards helping to challenge their existing negative public image. The exact wording of the interview question varied as it was tailored dependent upon the answers given to previous questions (i.e. in relation to how the NHS managers perceived their public image and whether they felt this affected them in any way). The following question which was used in one of the interviews relating to this issue exemplifies the general nature of the question asked:

*Interviewer: "To what extent do you think explicitly publicising the commitment of NHS managers towards behaving in a socially responsible manner within the NHS's existing formal CSR strategy would help challenge the existing negative public image of the NHS managers?"*

All the NHS managers except one expressed doubt to varying degrees about the extent to which having such an explicit statement included in the NHS's publicised CSR strategy alone would help challenge their existing negative public image. Some of the managers suggested the use of alternative strategies in addition to, or instead of, a revised publicised NHS CSR strategy as a measure towards challenging their negative public image. The following five quotes represent some of these views:

*"Yes (it would help challenge the negative public image), I think it would be worthwhile doing, but whether it would change public perceptions? These things take time and are subtle aren't they?"*

Nc10: Senior Manager, Non-clinical background.

*"I don't know that it will make a difference enough. I think the need for managers to justify their, you know commitment to the health service and so forth shouldn't be necessary. I think that the public perception will be what it will be because there will be*

*a story that will lead them down a path to believe that you know money is being wasted in these different ways so you know I'm not sure it will make enough difference...".*

C2: Senior manager, Clinical background.

*"I think it's not (currently) explicit...because for us everything we do is corporate social responsibility...I think we feel that that message (i.e. publicising the commitment of NHS managers towards their socially responsible behaviour) would get lost...it wouldn't be right for us to give it a high profile and our main business is corporate social responsibility...".*

Nc7: Senior manager, Non-clinical manager.

*"Yes (this approach may be effective though), I think what's got to come first is the experience rather than the definition so people will only get it when they actually experience it and then see it and you can end up defining it...and what happens is that we often have strategies and initiatives that define these things and people go "great posters, slogans, logos", you know a change in emphasis and then it doesn't translate into action".*

C4: Senior manager, Clinical background.

*I think it could be part of the challenge...we've just launched a major programme called "ABC" (name of programme changed to protect anonymity of Trust) which has a number of bits in it and a strong element in that is the work we've done around values based behaviours. So it's saying if these are values, we've got five, what sort of behaviours would we see that would tell you that staff were living those values...they are brilliant and it's early days but we've got different settings in which we are proposing they be used including treatment, appraisal, teambuilding settings and tons of work on how you would use them in those settings has been done...because I think the risk otherwise is that it could just sit in that strategy and probably most people here don't know what it is or ever see it and then it's just a tick in the box isn't it whereas if it is part of a range of approaches that are integrated it's much more effective".*

Nc9: Senior Manager, Non-clinical background.

One manager on the other hand did not feel that having such an explicit statement incorporated into the NHS publicised CSR strategy would help challenge their existing negative public image. In fact he felt that it would be best if only clinicians were promoted as far as the public were concerned in relation to being responsible for patient care and he thought that managers should be altogether excluded from the public focus with respect to this. The following quote expresses his views:

*“...in fact things would be ideal if the public didn’t even think there were managers involved in the equation. It’s the clinicians leading the service, making the decisions and driving the service...I think probably the best perception would be that the public didn’t even think that the managers were involved in the process, that it’s got to be a clinician led service...”.*

Nc5: Senior Manager, Non-clinical background.

In summary all but one of the NHS managers interviewed expressed doubt to varying degrees about the extent to which having an explicit statement relating to their commitment towards behaving in a socially responsible manner included within the NHS’s publicised CSR strategy alone would challenge their negative public image. Some of the managers suggested the use of alternative practice based strategies whereby the public and patients experience direct interaction with managers that actually demonstrate caring based values. This was suggested in addition to, or instead of, the use of a revised publicised NHS CSR strategy as a measure towards challenging their negative public image.



### **8.2.2 Findings: Private Healthcare Managers**

Although the private hospital involved in this study actively engaged in a wide range of CSR related initiatives and activities it had not adopted a formal publicised CSR strategy. When exploring what the private healthcare managers felt about their hospital adopting a formal publicised CSR strategy actively promoting the commitment and contribution of its staff (including managers) towards behaving in a socially responsible manner, the findings were quite different to those that emerged in relation to the interviews with NHS managers<sup>97</sup> since as reported in chapter 6 unlike the NHS managers, none of the private healthcare managers felt that the public viewed them negatively. In fact seven of the ten private healthcare managers interviewed in this study reported that they believed the public viewed them more positively than their NHS counterparts. The remaining three private healthcare managers as reported in chapter 6<sup>98</sup> indicated that they did not know what their public image was. Therefore the context for improving the private healthcare managers' public image through their hospital adopting a formal publicised CSR strategy promoting the commitment and contribution of its staff (including managers) towards behaving in a socially responsible manner was not relevant with regards to the private healthcare managers. Hence the private healthcare managers' views about the extent to which they felt their hospital should adopt a formal publicised CSR strategy was explored in a more general manner compared to the discussions undertaken with the NHS managers.

All the private healthcare managers were keen and enthusiastic about outlining the various CSR related activities that their hospital was actively

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<sup>97</sup> See section 6.2.2.

<sup>98</sup> See section 6.2.2.

engaged in and all but one of the ten private healthcare managers felt that their private hospital should adopt and publicise a formal CSR based strategy. The following four representative extracts from the interviews relay these views:

*“I think it would be really good, the other companies have it (i.e. a formal publicised CSR strategy), and we’re doing it but people don’t know about it, so it would be a good thing ...it would be good to have it on our website as well”.*

(NcJ: Middle Manager, Non-clinical background).

*“We have lots of processes in place, we have lots of things we’re doing which would fall into that area or remit. It’s not something we’ve formally put into place (i.e. a formal publicised CSR strategy) and it’s something we should definitely consider going forward from a corporate point of view. Commercially it’s a very viable option, it’s a very good idea. We’re starting to look at green issues. At the hospital itself we’ve started to see how we’re using our energy, how we could be more efficient, how we impact the environment so we’re looking at some of the green issues. We’re also looking at how we can benefit the local community in terms of apprenticeship schemes to help young people...there are lots of other aspects, we do lots of charity work, we’ve got a charity called XYZ (name changed to maintain anonymity of hospital) that we’re supporting which is a brain injury charity which links with our rehabilitation part of what we do in our business...there’s also type one diabetes which we’ve recently got involved in and we did a charity run for that organisation as well...”.*

(NcG: Senior Manager, Non-Clinical background).

*“It’s a good idea providing it isn’t sort of a ruse to get sort of more patients to come to us and I’d be uncomfortable with that if we were using it in a slightly surreptitious way to enhance the number of patients coming here but it’s a very positive thing as well if you can demonstrate yes we are private but we also want to give back because we’re already doing that in various ways but we don’t appear to publicise that”.*

(CC: Senior Manager, Clinical background).

*“I quite agree I think it would be kind of within the local area it would be good for the local environment and community to know that we are actually not just a money making machine but we do also want to do things that are ethically good for the environment and other people...”*

CA: Middle Manager, Clinical background.

One manager on the other hand did not feel it was necessary for the hospital to publicise its CSR activities as reflected in his interview extract below:

*“Well look at Shell, no matter what they do to try and give their corporate image a nice little look, they’re still the biggest pollutant in the world...all through the summer we do lots of things for charities but this is not something we should be banging on about how wonderful we are, we’re still a company after all, a profit making company”*.

NcF: Senior Manager, Non-clinical background.

Whilst nine of the ten managers reported that their private hospital should adopt and publicise a formal CSR based strategy, interestingly only two of the managers made a direct reference (as shown in the interview extracts below) for the need to include an explicit statement within the hospital’s publicised CSR strategy specifically related to the commitment and contribution of “managers” towards behaving in a socially responsible manner:

*“I think that (i.e. including an explicit statement relating to the commitment and contribution of managers towards working in a socially responsible manner within the hospital’s publicised adopted CSR strategy) could help in a way to remind the public that we are actually behind them in improving the service as they often only think of the clinicians who look after them and they tend to forget that there is a big organisation*

*behind them which actually runs the service they are receiving and so I think that would raise the profile of the managers”.*

CB: Senior Manager, Clinical background.

*“Ultimately everybody’s here to earn money and at the same time you must be here for reasons other than money and the majority of the people here want to do well by the patients and do want to provide a good service and make the difference and so maybe publicise those values or promote them externally which might help raise the perception of managers here. I’d be more than happy to do that...it’s not all just about taking, taking, taking which might be why managers are not seen negatively or positively (by the public) because here it’s all about they (the patients) see the therapists, the nurses, the dieticians, the consultants who treat them but not necessarily so much the management and that might be why there is no real sort of perception one way or another by the public of managers and having this might be one way of changing this public perception”.*

NcH: Middle Manager, Non-Clinical background.

In summary, all the private healthcare managers were keen to point out the various CSR related activities that their hospital is already actively engaging in and all but one felt that their private hospital should adopt and publicise a formal CSR strategy to actively promote and publicise their commitment towards behaving in a socially responsible manner.

Interestingly however only two of the managers felt the need to include an explicit statement within the hospital’s publicised CSR strategy specifically related to the commitment and contribution of “managers” towards behaving in a socially responsible manner.

### 8.3 Discussion

In the overall context of the aim of this study, this chapter seeks to address the final objective of this study which is “to critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers”. This is deemed to be important since, as discussed later in this chapter, it is generally held that the extent of an organisation’s success in effectively implementing its CSR strategy (irrespective of whether it is operating in the public or private sector) is to a large extent contingent upon the commitment, contribution and support demonstrated by its staff towards this strategy (Collier & Esteban, 2007).

This issue is particularly significant given the unique context of the NHS managers in that as reported in chapter 5<sup>99</sup>, the majority of the NHS managers interviewed in this study and those reported by a significant number of other studies (Mackenzie, 1995; Mellett & Marriott, 1995; Clarke & Yarrow, 1997; Young, 1999; Mannion et al., 2010; Jacobs et al., 2013) generally demonstrate an inherent commitment to altruistic based values and a commitment towards working in a socially responsible manner. However as reported in chapter 6<sup>100</sup> the findings of this study also show that all the NHS managers interviewed believed that the public viewed them negatively. It would therefore be useful in this context to examine the extent to which the NHS explicitly recognises the inherent commitment and contribution of its staff, including NHS managers, towards working in a socially responsible manner within its publicised CSR strategy. It could be argued that such an explicit recognition of the

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<sup>99</sup> See section 5.2.1.

<sup>100</sup> See section 6.2.1.

NHS managers' inherent commitment towards behaving in a socially responsible manner may go some way towards challenging the existing negative public image of the NHS managers. Relevant literature related to CSR and Social Responsibility<sup>101</sup> is drawn upon in this chapter to explore and discuss the main findings emerging from this study.

As outlined in chapter 3<sup>102</sup>, the concept of CSR, which has evolved significantly over the last five decades, has become increasingly popular in the 21<sup>st</sup> century with corporations globally as they adopt and implement strategies related to social responsibility for a myriad of reasons.

Challenges to the early view advocated by neo-classicists that organisations were only responsible and accountable to shareholders has led to the development of the more contemporary dominant position associated with the "stakeholder viewpoint" which recognises that organisations are responsible and accountable to a much wider range of stakeholders within society (Lee, 2008). Furthermore organisations have realised the financial and non-financial benefits of engaging in CSR related activities which include "improved financial performance, reduced operating costs and increased staff commitment" (Jones & Comfort, 2005, p. 48). These benefits have proven to be a strong stimulus for organisations globally towards adopting, implementing and actively publicising their CSR related strategies. Whilst the concept of CSR generally tends to be discussed mainly in the context of private sector organisations, these principles are also considered and applied to public sector and non-government albeit in the context of associated concepts such as "ethics", "social responsibility", "public accountability" and "citizen orientation" amongst others.

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<sup>101</sup> See section 3.5 for the literature review relating to CSR.

<sup>102</sup> See section 3.5.

When considering the employees' role within organisations, not only are employees recognised to be one of the key stakeholder groups but they also play a vital role in influencing the extent to which an organisation's CSR strategy is effectively implemented and successfully achieved. It is therefore widely held that the success of an organisation's CSR strategy is to a large extent contingent upon the commitment, contribution and efforts demonstrated by its staff towards this strategy (Collier & Esteban, 2007). Interestingly it appears that it is mainly private sector based organisations that tend to explicitly publicise the commitment and contribution of their staff towards the organisation's CSR endeavours within their CSR strategies (Jones et al., 2005; Lombard, 2012).

In contrast the publicised CSR strategies relating to NGOs and public sector organisations such as the NHS tend to instead be mainly externally focused towards for example emphasising their commitment to providing employment to the local community, engaging in ethical procurement strategies and contributing to reducing environmental pollution<sup>103</sup> (Dept. of Health, 2007; British Red Cross, 2009; Dept. of Environment, 2009). This latter approach also appears to be typical in relation to the CSR strategy adopted by the NHS (NHS, 2007; 2012).

Interestingly although many studies have reported that public sector staff including NHS managers hold altruistic based values and thereby demonstrate a strong commitment to behaving in a socially responsible manner (Mackenzie, 1995; Mellett & Marriott, 1995; Clarke & Yarrow, 1997; Mannion et al., 2010; Jacobs et al., 2013) yet surprisingly there appears to be an absence of any explicit indication within the publicised CSR strategies of public sector organisations, including the NHS, of the

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<sup>103</sup> As discussed in section 3.5.3.2.

commitment and contribution of their staff towards their organisation's socially responsible endeavours (Merali, 2010).

A review of the websites of various NHS Trust hospitals also reveals that there doesn't appear to be a standard centralised NHS CSR strategy evident. Whilst NHS Trusts appear to have developed independent approaches towards adopting strategies related to CSR, they tend to also be exclusively externally focused (for examples see the publicised CSR strategies of Barnet & Chase Farm Hospitals NHS Trust, 2012; Bolton NHS Primary Care Trust, 2012). The lack of reference to the commitment and contribution of internal stakeholders such as the staff of the organisation within the NHS publicised CSR strategy is especially significant as far as the NHS managers are concerned since as discussed in chapter 5<sup>104</sup>, the majority of the NHS managers interviewed in this study demonstrated an inherent commitment to altruistic based values and toward working in a socially responsible manner. Later in this discussion this will be considered in the context of the findings reported in chapter 6<sup>105</sup> whereby all the NHS managers interviewed in this study universally believed that the public held a negative image of them and did not recognise their commitment towards working in a socially responsible manner. This finding has also been supported by numerous other studies (Learmonth, 1997; Preston & Loan-Clarke, 2000; Ilett, 2011).

Whilst the public sector has tended to be regarded as a role model for the private sector in its approach to transparency and commitment to CSR (Michael & Gross, 2004) it has usually been the private corporations that appear for various reasons to be actively promoting their corporate and

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<sup>104</sup> See section 5.3.

<sup>105</sup> See section 6.2.1.



employees' commitment to socially responsible behaviour within their publicised CSR strategies (Moir, 2001). This also applies to private healthcare organisations such as Bupa<sup>106</sup> which promotes the commitment and contribution of its staff, including its managers, explicitly within its publicised CSR strategy (Bupa, 2009). There appears to be a general dearth in research exploring the relative merits of actively promoting the commitment and contribution of staff within publicised CSR strategies adopted by public sector organisations such as the NHS.

As discussed in chapter 5<sup>107</sup>, whilst the majority of the NHS managers interviewed in this study demonstrated an inherent commitment to altruistic based values and towards working in a socially responsible manner, all the NHS managers (as reported in chapter 6<sup>108</sup>) universally believed the public did not recognise this commitment and in fact held a negative image of them. In the main these managers attributed their negative public image to the anti-NHS management reports and stories widely publicised by the media along with the regular NHS manager-bashing exercised by the politicians for their own political expediencies. As discussed in chapter 6<sup>109</sup>, whilst half the NHS managers indicated that they were unaffected by their negative public image the remaining five managers reported that this misplaced negative public image did have a detrimental impact upon their morale and emotions. In some instances, as discussed in Chapter 7<sup>110</sup>, this appears to have led to the managers experiencing tensions in their identity work. It was within this context that it was felt worthwhile exploring the extent to which the NHS managers believed that having an explicit

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<sup>106</sup> See section 3.5.3.3.

<sup>107</sup> See section 5.3.

<sup>108</sup> See section 6.2.1.

<sup>109</sup> See section 6.3.

<sup>110</sup> See section 7.3.

statement reflecting their commitment and contribution towards behaving in socially responsible manner incorporated within the NHS's publicised CSR strategy may help challenge their existing negative public image.

As indicated in the findings section earlier in this chapter, all but one of the managers expressed doubt to varying extents about the effectiveness of such a stand-alone strategy. Some of the managers felt that since the media played a significant part in propagating this negative public image it was unlikely to buy into the agenda of publicising a positive image of NHS managers. It was also felt that the existing negative public image of NHS managers was propagated by politicians indulging in regular NHS manager-bashing for their own political expediencies and it seemed unlikely that the politicians would therefore change this habit. Some of the managers suggested the use of alternative parallel system-wide practice based strategies alongside a revised CSR strategy which publicised the commitment and contribution of NHS managers working in a socially responsible manner. They suggested implementing strategies whereby the public and patients had greater opportunities to directly interact with NHS managers so as to personally experience the extent of the managers' caring based values.

The managers felt that such dual strategies would prove more effective in challenging their negative public image. In fact some of the NHS managers indicated that such parallel system-wide strategies designed to improve and enhance the positive inter-relationship between NHS managers and the public were already in operation and gave specific examples of such strategies which included the "ABC" and "DEF"<sup>111</sup> initiatives which were

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<sup>111</sup> The names of these initiatives have been changed in order to safeguard the anonymity of the NHS Trust involved in this study.

already being implemented within the NHS Trust involved in this study. It was felt that building upon this more indirect approach towards enhancing and improving the actual experience the public and patients received when visiting the Trust/NHS would prove to be more effective in challenging and changing the negative public image of NHS managers rather than a stand-alone CSR strategy explicitly publicising the commitment and contribution of NHS managers towards working in a socially responsible manner.

It could be argued that an improved public perception of NHS managers through such a parallel system-wide integrated approach alongside an explicit statement in the NHS's CSR strategy could go some way towards challenging the NHS managers' negative public image. This in turn may have a positive impact on the managers' overall psyche and motivation and in turn upon their commitment and loyalty to the organisation. This is especially relevant since some of the managers as discussed in this study<sup>112</sup> reported experiencing tensions in their managerial identity and a detrimental impact on their morale as a result of their existing negative public image. Other benefits of the public's increased awareness of the NHS's commitment to CSR and ethical corporate policies either through direct and/or indirect means is also likely to result in improved staff morale as reported by Cramer (2003), greater job satisfaction (Koh & Boo, 2004) and effective staff recruitment (Oketch, 2004). Such a boost to the managers' psyche would help ensure that managers continue their positive contribution in line with Scott's study (2002) which found that the perception of feeling valued was an important factor in the retention of managers within the NHS.

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<sup>112</sup> See section 7.3.

The current government initiative of encouraging and involving users of public services in determining public policy (Barnett, 2002) could also be another means to increase public awareness of the valuable ethical contribution made by NHS managers. Such mechanisms for NHS managers to demonstrate their commitment to the NHS altruistic ethos in a more visible and overt way should also help develop a more positive public image of their role. Whilst it is recognised that it is difficult to measure and assess corporate social performance (Moir, 2001), the NHS Trusts could actively publicise, through their corporate literature, the contribution NHS managers have made towards enhancing the effectiveness and efficiency of the NHS and emphasise how this in turn has added value to overall delivery of patient care.

It is likely that an improved public image of NHS managers will also have an impact on those managers who may have not consciously joined the NHS with altruistic motives as a greater awareness of their socially responsible role would lead them to actively explore for any deep rooted held values and thereby enhance their overall commitment and contribution to the NHS. Furthermore politicians also need to refrain from attempting to escape political accountability by regarding NHS managers as scapegoats for failure of government policy. A combination of these measures should go some way towards creating an environment in which the public can build a more positive image of NHS managers which apart from addressing the issues above may also contribute towards mitigating the current recruitment and retention difficulties associated particularly with nurse-managers in the UK (Kirpal, 2004; Wise, 2007).

As far as the CSR strategy of the private hospital involved in this study is concerned, interestingly whilst the hospital had not adopted a formalised

CSR strategy, the private healthcare managers during the various interviews proudly recounted the wide range of CSR related activities that their hospital was actively engaged upon throughout the year. Examples included events raising funds for various local and national charities through a diverse range of activities such as staff charity runs and cake sales along with various codes of conduct like the “123” code of conduct<sup>113</sup> requiring the fair and ethical treatment of co-workers. The context for exploring what the private healthcare managers felt about their hospital adopting a formal publicised CSR strategy promoting the commitment and contribution of its staff (including managers) towards working in a socially responsible manner was different to that explored with NHS managers since as reported earlier in this thesis<sup>114</sup>, unlike the NHS managers, none of the private healthcare managers interviewed in this study felt that the public viewed them negatively. Therefore the issues examined during the interviews with the private healthcare managers were not related to exploring ways to challenge their public image but with exploring their views more generally about the extent to which they felt their hospital should adopt a formal publicised CSR strategy and whether this strategy should explicitly include a recognition of the commitment and contribution of staff. The findings related to this issue resulted in some interesting insights.

As reported earlier in this chapter, whilst all ten of the private healthcare managers were keen and enthusiastic about recounting the various CSR related activities that their hospital was actively engaged in, nine of the ten private healthcare managers felt that their private hospital should adopt and

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<sup>113</sup> The title of the code of conduct has been changed in order to maintain the anonymity of the hospital involved in this study.

<sup>114</sup> See section 6.2.2.

publicise a formal CSR strategy. They believed this would prove useful in not only publicising their hospital's wide ranging CSR endeavours to the local community but they felt that adopting a formal CSR Strategy also corresponded to the current industry norm. However one manager who supported the idea of the hospital adopting a publicised CSR strategy was also keen to indicate that this strategy should only be used for providing information about the organisation's CSR endeavours rather than used in a manipulative PR stunt to attract private patients. Another manager on the other hand disagreed with the view that the hospital should adopt a formal publicised CSR strategy in which it promoted its support and active involvement in CSR related activities as he felt that there was no need to cynically flaunt this since the main objective of the hospital at the end of the day was essentially to make a profit.

Whilst nine of the ten managers felt that their private hospital should adopt and publicise a formal CSR strategy, only two of the managers made a direct reference for the need to include an explicit statement within the hospital's publicised CSR strategy specifically related to the commitment and contribution of managers towards behaving in a socially responsible manner. These two managers felt that this would raise a more positive profile of private healthcare managers in the public eye (one of the managers believed that unlike the situation with NHS managers, the public did not have any preconceived views or perceptions of private healthcare managers).

## **8.4 Synopsis & Concluding Remarks**

The extent of an organisation's success in effectively implementing its CSR strategy (irrespective of whether it is operating in the public or private sector) is to a large extent contingent upon the commitment, contribution and support demonstrated by its staff towards this strategy (Hemingway & MacLagan, 2004; Collier & Esteban, 2007). This issue is recognised to be particularly significant given the unique context of the NHS managers (as reported in this and earlier chapters) whereby the majority of the NHS managers interviewed in this study as well as reported in a significant number of other studies (Mackenzie, 1995; Mellett & Marriott 1995; Clarke & Yarrow, 1997; Young, 1999; Mannion et al., 2010; Jacobs et al., 2013) demonstrate an inherent commitment to altruistic based values and towards working in a socially responsible manner. At the same time all the NHS managers interviewed in this study also universally reported that they believed the public held a negative image of them. It was in this context that the NHS's current publicised CSR strategy was critically evaluated to assess the extent to which it recognises the commitment and contribution of its staff, including NHS managers, particularly since there appears to be lacunae in existing research which explores the merits of actively promoting the commitment and contribution of staff within the publicised CSR strategies of public sector organisations such as the NHS. Relevant literature related to CSR has been drawn upon to discuss and develop insights into the main findings emerging from this study.

Although the NHS has a formal publicised CSR strategy it, like many other NGOs and public sector organisations, is mainly externally focused in relation to for example creating jobs in the local communities, developing ethical corporate policies such as those relating to purchasing and supply

and reducing its carbon footprint in the environment. Unlike many private sector organisations, including private health organisations such as Bupa, there appears to be an absence of any explicit recognition of the commitment and contribution of the NHS staff (including NHS managers) towards working in a socially responsible manner within the NHS's publicised CSR strategy. It was within this context that the issue of having an explicit publicised CSR strategy statement reflecting the NHS managers' commitment and contribution towards working in socially responsible manner in order to help challenge the managers' existing negative public image was explored with the NHS managers during the primary research interviews.

The findings of this study revealed that NHS managers expressed considerable doubt about the effectiveness of such a stand-alone strategy. They felt that since the media and the politicians played a significant part in propagating this negative public image they were unlikely to buy into the agenda of publicising a positive image of NHS managers. Some of the NHS managers therefore suggested the use of alternative parallel system-wide practice based strategies, alongside a revised formal CSR strategy publicising the commitment and contribution of NHS managers. In fact some of the NHS managers indicated during the interviews that such system-wide strategies designed to improve and enhance the relationship between NHS managers and the public were already in operation to varying extents within their Trust. It was felt that this hands-on approach would prove to be more effective in challenging and changing the negative public image of NHS managers rather than a stand-alone CSR strategy explicitly publicising the commitment and contribution of NHS managers towards working in a socially responsible manner.



An improved public perception of NHS managers brought about through such a parallel integrated approach is likely to have a positive impact on the managers' psyche and motivation and in turn their commitment and loyalty to the organisation. This is particularly significant given that some of the managers in this study experienced tensions in their managerial identity as a direct result of their negative public image. Other benefits could include improved staff morale, greater job satisfaction and the retention of committed managers within the NHS. It is likely that an improved public image of NHS managers will also have an impact on those managers who may not have consciously joined the NHS with altruistic motives and in such cases raise an awareness of their socially responsible role and thereby lead them to explore their deep rooted values.

As far as the private healthcare managers interviewed in this study are concerned, since none of them believed that the public viewed them negatively the context for exploring their views about issues related to CSR was therefore not related to challenging their public image, as was the case with the NHS managers, but more to do with exploring their views about this issue in a more general manner. Whilst the majority of the private healthcare managers felt that their hospital should adopt a formal publicised CSR strategy, only two managers felt any need for such a formal publicised CSR strategy to include an explicit statement regarding the personal commitment and contribution of private healthcare managers towards behaving in a socially responsible manner.

Overall the insights generated from this chapter have contributed towards an understanding of this relatively under researched field. Possible strategies towards effectively challenging the existing negative public image of NHS managers have also been considered within this chapter. The

next chapter provides an overview and summary of the study reported in this thesis. It outlines the key conclusions emerging from the study and considers their practical implications. In addition to outlining the contribution to knowledge made by the study, the final chapter also highlights the significance of this study together with its limitations and identifies potential avenues for further research.

## **Chapter 9: Summary, Conclusions, Practical Implications & Scope for Further Research**

### **9.1 Introduction**

This final chapter provides an overview and summary of the study. It begins by outlining the study aim, objectives, context and rationale followed by revisiting the four objectives driving this study. The chapter then goes on to summarise the theoretical contributions made by this study through highlighting the key findings associated with each of the four objectives. Next the main conclusions emerging from this study and their practical implications are discussed. Finally in addition to outlining the contribution to knowledge made by this study, the significance of this study and its limitations along with possible avenues for further research are highlighted.

#### **9.1.1 Study Aim, Objectives, Context & Rationale**

The main aim of this study as outlined in chapter 1 is “to critically examine the NHS managerial culture in the context of the challenges and tensions facing the 21<sup>st</sup> century NHS managers”. The following section summarises the background context and rationale for this study.

As explained in chapter 2, the NHS was set up in 1948 with the main principle of providing free care to all UK citizens. This year as the NHS celebrates its 66<sup>th</sup> anniversary it has grown to be the largest organisation in Europe employing in excess of 1.3m people which includes about 37,200 managers (NHS Confederation, 2013). This giant UK public sector organisation not only commands a world class reputation for providing top quality healthcare free at the point of delivery but is subjected to constant

and significant public scrutiny. Its sheer size, high public profile and complexity of operations, apart from making it political dynamite, also makes it interesting to a very broad range of stakeholders which includes government policy formulators, practitioners, academics and the general public at large. Since its birth in 1948 the NHS has evolved through a plethora of government led reforms as it has adapted to the dynamic UK economic and political landscape.

As it accustoms to the second decade of the 21<sup>st</sup> century the NHS is facing difficult and challenging times in seeking to continue to deliver high quality free care especially in the context of the current austerity drive typical of the political, economic and social landscape affecting much of Europe. This year the NHS is experiencing yet another wave of major reforms designed by the current Conservative-Liberal coalition government and precipitated by the Health & Social Care Act 2012. The scale of these current reforms is however unprecedented to the extent that Sir David Nicholson, the Chief Executive of the NHS has described them as being large enough to be “seen from space” (BBC News, 2013). NHS managers continue to play a crucial role in the NHS as they are charged with the main responsibility for successfully implementing the never-ending government reforms and achieving challenging government targets so as to continuously develop an ever more efficient, effective and accountable organisation. Given this crucial role of NHS managers within the NHS, this study has aimed to critically examine the NHS managerial culture in the context of the challenges and tensions they face in the 21<sup>st</sup> century NHS.

Given the sheer size, significance and wide interest that the NHS attracts globally it is not surprising that there is a vast amount of research already reported in the various public and academic domains relating to almost

every aspect of the NHS including the NHS managerial culture. However due to the highly political and dynamic nature of the NHS, the research undertaken and reported related to it is far from exhaustive. In the context of the NHS managerial culture which is the main focus of this study, newer or different avenues of research appear to be emerging just as fast if not faster than existing areas have been explored. These new avenues emerge for a variety of reasons which include the on-going metamorphosis of the NHS as it is subjected to a never ending cycle of reforms and their resultant implications for the NHS managerial culture. This is further combined with the quest by researchers and academics to discover and develop different and richer insights and understanding of the NHS managerial culture through the application of existing and newly developed ideas and theories. In a similar vein this study has aimed to contribute towards developing the existing knowledge related to the NHS managerial culture through providing deeper and richer insights into the key issues central to the aim and objectives of this study as outlined below.

### **9.1.2 Objectives of the Study**

The achievement of the aim of this study was facilitated through the pursuit of the following four specific objectives as outlined in chapter 1:

1. To identify and explore the NHS managers' perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner.
2. To explore the healthcare managers' views of their public image and to investigate the extent to which they believe this image affects their psyche and their overall commitment and contribution to the NHS.
3. To explore the healthcare managers' self and work identities.

4. To critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers.

The following section provides a summary of the key findings associated with each of these objectives and highlights how they individually and collectively contribute towards developing the existing research and knowledge in the field.

## **9.2 Summary: Theoretical Contribution**

In order to understand the contribution to knowledge made by this study it would be useful to highlight the background context and the relative novelty of the findings of this study in relation to the existing published literature in this field. The following section therefore provides an overview of the key findings associated with each of the four objectives driving this study and discusses how they contribute towards developing the existing research and knowledge in the field. The main similarities and differences emerging from the findings in relation to the two groups of healthcare managers involved in this study (i.e. the NHS managers and the private healthcare managers) are also highlighted within the overview provided below.

### **9.2.1.1 Objective 1**

The first objective which formed the central basis for discussion in chapter 5 was “to identify and explore the NHS managers’ perceived core values and whether these relate in any way towards a commitment to working in a socially responsible manner”. As discussed in chapters 3 and 5, there already exists a significant body of reported scholarly research in relation

to the NHS managerial culture and the NHS managers' core values. In general terms much of this research appears to share consensus in the view that NHS managers, and for that matter public sector staff, hold altruistic based values. However the majority of these studies appear to have neglected an explicit and in-depth examination of the relative strength of the NHS managers' commitment towards such values. Instead as discussed in chapter 5, these studies have often tended to conclude that NHS managers hold altruistic based values either through exploring this issue in a relatively indirect or peripheral manner or through the use of mainly quantitative based surveys that do not provide the deeper contextual insights typical of qualitative based approaches. Consequently there appears to be a relative lacunae in existing research which explores in a more direct and deeper manner the relative strength of this commitment by NHS managers towards altruistic based values and the extent of their commitment towards working in a socially responsible manner. The study reported in this thesis has addressed this relative gap in the existing research.

As discussed in chapter 5, the findings of this study revealed that six of the ten NHS managers with both clinical and non-clinical backgrounds reported altruistic motives underpinning their reasons for choosing to work in a healthcare environment such as the NHS. This strong commitment to the NHS values demonstrated by the NHS managers interviewed in this study was reinforced not only by their long term on-going employment in the NHS (of about twenty seven years on average<sup>115</sup>) but also by the view expressed by nine of the ten NHS managers that given the benefit of hindsight of their experiences in the NHS they would repeat their decision

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<sup>115</sup> As shown in Appendix D.

to join to work in the NHS because of these values. Furthermore this view was often expressed very emphatically and without any hesitation.

Although the findings in this study only represent the views of ten NHS managers, they serve to reinforce the observations of a separate research study previously reported by the author in 2006. In that study fifteen of the twenty NHS managers who came from both clinical and non-clinical backgrounds and were working in two different NHS Trusts also reported that they had actively sought the opportunity to work in a caring based profession underpinned by altruistic values. All but one of the managers interviewed in that study also reported that they would repeat their decision to join to work in the NHS given the benefit of hindsight of their experiences in the NHS. Furthermore the findings from another earlier separate study reported by the author in 2005 which involved in-depth interviews with twenty eight NHS managers working in three different NHS Trusts also demonstrated that the majority of the managers interviewed in that study held values that were mainly altruistic in nature. The overall validity and reliability of the findings in this thesis are therefore strengthened by their similarity to those reported by the author's previous studies. These findings in conjunction with other published studies as discussed in chapter 5 demonstrate that the majority of NHS managers have a strong inherent commitment to altruistic based values to the extent that many of the managers appear to have actively sought the opportunity to work in a caring based profession underpinned by altruistic based values such as the NHS thereby demonstrating their strong commitment towards working in a socially responsible environment and manner. This of course does not necessarily imply that the NHS managers are entirely immune from indulging in momentary short-term cynical



expediencies which may at times seem to be at odds with their inherent altruistic based core values.

Whilst a minority of NHS managers interviewed in the study reported in this thesis expressed other reasons such as personal enhancement and career development which had led them to join the NHS, often these reasons were quoted alongside rather than instead of the altruistic based values. This was similarly also the case in the two studies reported by the author previously. As far as the private healthcare managers interviewed in this study were concerned, as reported in chapter 5, six of the ten managers from both clinical and non-clinical backgrounds also expressed altruistic motives underpinning their reasons for choosing to work in the healthcare environment. However these findings in themselves cannot be automatically interpreted to suggest the existence of a similar unique altruistic based managerial culture in the private healthcare sector given that half the private healthcare managers with a clinical background involved in this study had also previously worked for the NHS for between four and twelve years as part of their original training. When the private healthcare managers were asked whether they would once again repeat their decisions to work in the healthcare environment today with the benefit of hindsight, nine of the ten managers responded positively and in most cases without any hesitation.

Overall these findings contribute towards developing existing knowledge in this field in two main ways. Firstly as explained earlier whilst there are several existing studies that have reported that NHS managers hold altruistic based values there appears to be a relative lacunae in existing research exploring in a deep and direct manner the relative strength of the NHS managers' commitment towards altruistic based values and the extent

of their commitment towards working in a socially responsible manner. The findings in this study in conjunction with those reported by the author previously have addressed this relative gap in the existing research by identifying through in-depth interviews the NHS managers' strong altruistic based values and thereby their strong commitment towards working in a socially responsible manner. Secondly the findings reported in this study provide interesting insights into the wider healthcare managerial culture as a result of the comparative interviews conducted with the private healthcare managers. These interviews revealed that six of the ten private healthcare managers (with both clinical and non-clinical backgrounds) also reported that altruistic motives had underpinned their reasons for choosing to work in the healthcare environment. However as already mentioned generalisations cannot be inferred in relation to these findings for the wider private healthcare managerial culture given that half the private healthcare managers involved in this study with a clinical background had also previously worked for the NHS. More research in relation to exploring this issue with a larger sample population would therefore prove useful in this regard.

#### **9.2.1.2 Objective 2**

The second objective which was the main focus for the discussion in chapter 6 was "to explore the healthcare managers' views of their public image and investigate the extent to which they believe this affects their psyche and their overall commitment and contribution to the NHS".

As discussed in chapter 6, whilst there are several published studies which have reported that NHS managers believe that the public view them negatively there appears to be a dearth in reported research exploring in

any great depth the extent to which the NHS managers (from both clinical and non-clinical backgrounds) experience any tensions and challenges as a result of this negative perceived public image. This study has addressed this relative gap in knowledge by exploring and examining in a direct and explicit manner how healthcare managers perceive their public image and the extent to which they feel that this affects them and impacts on their overall commitment and contribution to the NHS.

All the ten NHS managers interviewed in this study believed that the public viewed them negatively and this finding is also supported by other reported studies. The NHS managers primarily attributed this belief to the moral panic caused by the widely publicised detrimental media reports and stories about them along with the regular public NHS manager-bashing exercised by the politicians for their own instrumental interests. Interestingly only one NHS manager during a repeat interview indicated that he felt there had been some improvement in the NHS managers' public image since his last interview reported by the author previously. Although he attributed this improvement to the outcomes of some of the reforms introduced in the NHS by the last Labour government, he maintained his view from the last interview that the overall public image of NHS managers still remained poor. Furthermore emotions of demoralisation, frustration, irritation and anger felt as a direct or indirect effect of the managers' perceived negative public image were reported by half of the NHS managers from both clinical and non-clinical backgrounds who were interviewed in this study. New Institutional Theory and in particular the pressures stemming from normative isomorphism (DiMaggio & Powell, 1983) provided a valuable framework in chapter 6 to explore and discuss these findings and the implications arising therein.

Therefore whilst the majority of the NHS managers' demonstrate a strong inherent commitment to altruistic based values and towards working in a socially responsible manner (as identified through the first objective of this study) they believe the public do not recognise their commitment and in fact view them negatively. Although the findings reported in this study represent the views of only a small sample of NHS managers, these findings are further reinforced and their overall validity and reliability strengthened when considered in relation to the similar findings reported by the author in connection with two separate previously reported studies. Some of the possible measures to challenge the negative public image of NHS managers in order to mitigate the consequent emotions, tensions and challenges experienced by the NHS managers were considered in chapter 8.

With regards to the interviews conducted with private healthcare managers, interestingly seven of the ten private healthcare managers reported that they believed the public held a more positive view of them compared to their NHS counterparts and in fact none of the private healthcare managers reported that the public viewed them negatively. Given the unanimous nature of this latter view expressed by the private healthcare managers interviewed in this study, it is therefore argued in this thesis that the issue related to the NHS managers' negative perceived public image appears to be an issue that is unique to the NHS managerial culture rather than one more widely relevant to the UK managerial healthcare sector in general.

In conjunction with the first objective, the findings related to this objective therefore provided interesting and unique insights into issues affecting the NHS managerial culture. In particular this was derived from developing a deeper and richer understanding of the extent and prevalence of the view

held by NHS managers that the public view them negatively and importantly the extent to which this is in turn affected them. Therefore overall these findings provide relatively novel insights into this area given the relative lack of existing reported research exploring in any great depth the extent to which the NHS managers experience tensions and challenges as a result of their negative perceived public image.

### **9.2.1.3 Objective 3**

The third objective as discussed in chapter 7 was “to explore the healthcare managers’ self and work identities”. This objective sought to explore the implications of the findings and insights developed through the first two objectives in relation to the healthcare managers’ self and work identities. The significance of exploring the healthcare managers’ self and work identity as discussed in chapter 7 is based on the view that how managers perceive their self and work identities and how they see themselves as perceived by others has important implications for their work performance, commitment and satisfaction (Kirpal, 2004; Blenkinsopp & Stalker, 2004).

As outlined in chapters 3 and 7, whilst there are a number of existing studies which have explored and provided valuable insights into a wide range of issues connected to the (re)construction of the NHS managers’ self and work identities, there appear to be a deficiency in studies which have specifically explored in any great depth and in a direct manner the implications of the NHS managers’ negative perceived public image for their self and work identities. The study reported in this thesis has addressed this relatively neglected research area through drawing upon Alvesson & Willmott’s (2002) theoretical framework to explore and develop insights into the tensions and challenges experienced in the self

and work identities of the NHS managers consequent to their negative perceived public image. More specifically these insights were developed through exploring how the healthcare managers involved in this study would introduce themselves to a stranger at a party. The managers' responses to this situation were considered in the context of the findings related to other relevant issues explored in the interviews such as the managers' reasons for joining the NHS (as discussed in chapter 5) and their views of their public image (as discussed in chapter 6). This approach allowed for the development of a more holistic and deeper understanding of the complexities of the issues connected to the managers' self and work identities.

When exploring how the four NHS managers with a clinical background (who all performed exclusively or predominantly managerial functions with either very little or no clinical duties) felt about their identity in relation to their formal occupational title of "NHS manager", it was found that only one manager was candid about introducing herself by her managerial title to a stranger at a party. Two managers appeared to be defensive about their managerial titles when making introductions with a stranger because they felt the public viewed NHS managers negatively. The remaining manager appeared to conceal her managerial title and indicated that she would introduce herself by her clinical background because she believed the public would be more impressed by her clinical rather than her managerial role. As far as the six managers with a non-clinical background were concerned, whilst unsurprisingly they all indicated that they would introduce themselves to a stranger at a party by their managerial title, one of these managers appeared to be defensive about openly admitting his

managerial ties to the NHS because he believed the public held a negative image of NHS managers.

In relation to the private healthcare managers, it was clear from the interviews that all five of the private healthcare managers from a non-clinical background had no inhibitions about introducing themselves to strangers at a party by their formal managerial titles. In contrast as far as those private healthcare managers with a clinical background were concerned whilst one manager indicated he would introduce himself to a stranger by his formal managerial title (though he appeared to be somewhat defensive about this), the remaining four managers interestingly appeared to conceal their formal managerial titles and instead preferred to introduce themselves to strangers at a party by their clinical backgrounds. This was mainly because the managers again believed that the public viewed clinical occupational roles in higher esteem than managerial roles. Furthermore three of these private healthcare managers also appeared to personally identify more strongly with their clinical occupational backgrounds and identities despite performing predominantly or exclusively managerial functions.

The findings of this study related to the self and work identities of healthcare managers provided interesting insights into issues that do not appear to be restricted only to the NHS managerial culture but also appear to be more widely pertinent to the broader managerial healthcare environment. Drawing on Alvesson & Willmott's (2002) theoretical framework which highlights the complex interrelationship between three key influencing factors namely "self-identity", "identity regulation" and

“identity work”<sup>116</sup> it is argued in this thesis that tensions related to the managerial identity of the healthcare managers can be attributed to a multitude of factors related to “identity regulation”. As far as the NHS managers are concerned, this mainly relates to the prevalence of a dominant negative NHS managerial discourse fuelled by the regular NHS manager-bashing exercised by politicians for their own political expediencies and by the constant flow of negative stories and reports about NHS managers publicised by the media.

Two of the NHS managers with a clinical background involved in this study had also participated in an earlier separate study reported by the author in 2006. They voiced identical views to those in their previous interviews (i.e. one manager indicated that she would conceal her managerial identity whilst the other was defensive about revealing her managerial identity to a stranger at a party) but an interesting novel insight emerged from a repeat interview conducted with a manager who had a non-clinical background in relation to this issue. In the previous reported study the author had not explored the issue of how managers with a non-clinical background would introduce themselves to a stranger as it had been assumed that all managers from a non-clinical background would have no option other than to introduce themselves by their managerial titles to strangers (whilst managers with a clinical background at least had the option of introducing themselves by their clinical titles if they preferred). However interestingly as reported and discussed in chapter 7, the repeat interview in this study with the manager who had a non-clinical background revealed that he too was defensive about revealing his NHS

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<sup>116</sup> See section 3.4.4 for an explanation of Alvesson & Willmott’s (2002) theoretical framework.



managerial ties thereby demonstrating tensions in relation to his managerial identity.

A common factor attributed to causing tensions in the identity work of both NHS and private healthcare managers with clinical backgrounds appears to be the prestige that the healthcare managers believe society attributes to the clinical profession unlike the managerial role, as explored in chapter 7. In the case of the private healthcare managers with a clinical background the tensions evident in their identity work also seem to be attributed to the strong sense of identity and affiliation these managers appear to have to their clinical professional roles (rather than to their managerial identity) and which they felt inherently defined who they were. This could be attributed not only to the strength of the managers' personal values but also to aspects connected to "identity regulation" (as identified in Alvesson & Willmott's (2002) theoretical framework) in relation to the norms and values cultivated and promoted through discourses associated with professional bodies in the wider clinical professions.

The insights and implications of the NHS managers' negative perceived public image on their self and work identities developed through this study provide a unique and valuable contribution towards developing the existing knowledge in this relatively under-researched area.

#### **9.2.1.4 Objective 4**

The final objective which formed the focus for discussion in chapter 8 sought "to critically evaluate the CSR strategy adopted by the NHS with a view to examining the extent to which it reflects the personal commitment and contribution of NHS managers". As explained below the overall significance of the findings related to this objective is more fully

understood when considered in conjunction with how it relates to and builds upon the findings connected to the previous three objectives driving this study.

The main findings associated with first objective of this study as outlined earlier revealed that the majority of the NHS managers interviewed in this study demonstrated an inherent commitment to altruistic based values and a strong commitment towards working in a socially responsible manner. However as demonstrated by the findings related to the second objective, all the NHS managers interviewed in this study believed that the public viewed them negatively and that the public did not recognise their commitment towards working in a socially responsible manner. The managers believed that their negative public image was fuelled mainly by the manager-bashing regularly exercised publically by the politicians for their own political expediencies along with the widely publicised detrimental media reports about them. Furthermore emotions of demoralisation, frustration, irritation and anger were reported by half the NHS managers from both clinical and non-clinical backgrounds interviewed in this study as a result of their negative perceived public image.

The implications of the managers' negative perceived public image were explored in relation to the third objective of this study whereby some of the NHS managers reported experiencing tensions and challenges related to their self and work identities primarily due to the prevalence of a dominant negative NHS managerial discourse perpetuated by the politicians and media. Given these collective findings associated with the first three objectives, the final objective of this study sought to identify the extent to which the current CSR strategy adopted and publicised by the NHS

reflected the personal commitment and contribution of NHS staff (including NHS managers) towards working in a socially responsible manner. This was considered as a possible avenue through which the NHS managers' negative public view could be challenged.

Relevant literature related to CSR and the extent to which private and public sector organisations reflect the commitment and contribution of their staff within their publicised CSR strategies provided a useful framework in chapter 8 for the critical evaluation of the current CSR strategy adopted by the NHS. Whilst there appears to be abundant reported studies available in the academic and public domains related to most aspects of CSR, as discussed in chapter 8 there appear to be a lacunae of studies which explore the merits or otherwise of actively promoting the commitment and contribution of staff within the publicised CSR strategies related to public sector organisations such as the UK NHS. This study therefore sought to contribute towards developing an understanding of this neglected area of research.

The research undertaken in this study revealed that although the NHS does have a formal publicised CSR strategy, this strategy like that of many other NGOs and public sector organisations is mainly externally focused covering a broad range of aspects such as those related to creating jobs in the local communities, developing ethical corporate policies (for instance connected to purchasing and supply) and reducing the organisation's carbon footprint in the environment. Unlike many private sector organisations, including private health organisations such as Bupa, there appears to be an absence of any explicit recognition of the commitment and contribution of the NHS staff (including NHS managers) within the NHS's publicised CSR strategy. It was in this context that the extent to which the

NHS managers felt that having an explicit statement reflecting their commitment and contribution towards working in socially responsible manner was explored. They were asked if having this incorporated within the NHS's publicised CSR strategy would help challenge their existing negative public image.

The findings as discussed in chapter 8 revealed that all but one of the NHS managers interviewed in this study expressed doubt to varying extents about the effectiveness of such a stand-alone strategy. They felt that since the media played a significant part in propagating their negative public image it was unlikely to buy into the agenda of a publicised CSR strategy which promoted a more positive image of NHS managers. Furthermore it was also felt that politicians were unlikely to refrain from their regular NHS manager-bashing in order to serve their own political expediencies. For these reasons the NHS managers felt that any efforts by the NHS to publicise a stand-alone CSR strategy that promoted a positive image of NHS managers would be likely to be fruitless.

On the other hand some of the managers however proposed the implementation of locally devised strategies designed to promote and encourage greater interaction between the public and NHS managers alongside a revised CSR strategy publicising the commitment and contribution of NHS managers towards working in a socially responsible manner. For example they suggested increasing the presence of managers in the public view when patients attended out-patient clinics in the hospitals. The managers felt that actively promoting their public profile positively within the hospital environment through providing a greater opportunity for the public and patients to interact with NHS managers would allow them to directly demonstrate and promote their patient-centred

and caring based values. The managers believed that such strategies would prove more effective in challenging the managers' negative public image at the public grass root levels. In fact some of the NHS managers interviewed in this study reported that such types of strategies designed to improve and enhance the relationship between NHS managers and the general public were already underway to some extent in their NHS Trust. It was felt that this more hands-on approach towards enhancing and improving the actual experience patients received when interacting with NHS managers would prove to be more effective in challenging and changing the negative public image of NHS managers rather than a stand-alone CSR strategy explicitly publicising the commitment and socially responsible contribution of NHS managers.

The background for exploring what the private healthcare managers felt about their hospital adopting a formal publicised CSR strategy promoting the commitment and contribution of its staff (including managers) towards working in a socially responsible manner was different to that explored with NHS managers since (as reported in chapter 6) unlike the NHS managers, none of the private healthcare managers felt that the public viewed them negatively. Interestingly as explained in chapter 8 although the private hospital involved in this study actively engaged in a wide range of CSR related initiatives and events it did not have a formal publicised CSR strategy in place.

The findings of the interviews undertaken with the private healthcare managers in this study proved valuable in two main ways. First, as discussed in chapter 8, the findings emphasised the unique nature of the issue in relation to the negative perceived public image facing the NHS managerial culture since none of the private healthcare managers felt that

the public viewed them negatively. Secondly whilst the majority of the private healthcare managers felt that their hospital should adopt a formal publicised CSR strategy, only two managers felt the need for this formal publicised CSR strategy to include an explicit statement regarding the personal commitment and socially responsible contribution of private healthcare managers. Both these managers felt that such an explicit statement would go some way towards raising a positive profile of private healthcare managers in the public eye given that one of the managers believed that the public did not have any preconceived views or perceptions of private healthcare managers.

The insights generated from the findings associated with the final objective proved useful in contributing towards developing the existing knowledge in relation to exploring possible ways in which the NHS managers' existing negative public image could be effectively challenged. Furthermore the findings related to this objective also provided some interesting insights into issues related to managers working in the private healthcare environment.

All of these four objectives collectively facilitate the achievement of the research aim through generating insights into the realities, views and perceptions of the healthcare managers with regards to the key issues central to the study. It is important to re-emphasise that these objectives were approached in an interconnected manner such that the knowledge and insights developed from the findings associated with the first objective was built upon in an incremental manner through the pursuit of the second objective. Similarly the findings collectively associated with the first two objectives were built upon further through the pursuit of the third objective which in turn provided a valuable basis for collectively exploring the final

objective. The achievement of each objective proved valuable in contributing towards developing the existing research and knowledge related to the specific theoretical context framing each of the objectives and has also collectively contributed towards advancing the existing research related to the evolving nature of the NHS managerial culture.

### **9.3 Key Conclusions & their Practical Implications**

This study, through the proxy of NHS managers, has demonstrated that some groups of workers tend to gravitate towards organisations whose value systems complement their own. In the case of the NHS managers, this study in conjunction with other published studies has shown that the majority of the NHS managers have a strong inherent commitment to altruistic based values. Furthermore many of them appear to have actively sought the opportunity to work in a caring based profession underpinned by altruistic based values thereby demonstrating their strong commitment towards working in a socially responsible manner. These findings are particularly significant when considered in the context of the current drive to transform the NHS managerial culture into one that is even more market driven and goal oriented as discussed in chapter 5. The findings from the study reported in this thesis (which are also supported by the findings reported by the author in two separate studies published in 2005 and 2006) suggest that this change is likely to continue to be underpinned by a desire by NHS managers to work in a socially responsible manner despite the increasing and continued marketisation of the NHS.

This thesis has also raised the question “what happens when an individual with altruistic based values joins a matching organisation but then perceives that he or she is instead considered by the public to be heartless and the villains of the piece?” As demonstrated by the findings of this study some of the managers, with both clinical and non-clinical backgrounds, reported feeling emotions of demoralisation, frustration, irritation and anger as a result of their poor perceived public image which appears to have had a negative influence on their self and work identity. It has been argued in this thesis that a greater awareness by the public and other stakeholders of the actual activities undertaken by NHS managers and how these fit into the altruistic ethos of the NHS would prove valuable in challenging the NHS managers’ existing negative public image.

Possible ways to mitigate the tensions and challenges experienced by the NHS managers in relation to their self and work identities as a result of their negative perceived public image have also been explored in this thesis. This includes developing existing policy which explicitly promotes the NHS managers’ commitment towards working in a socially responsible manner within the NHS’s publicised CSR strategy so as to increase the general public’s awareness of the managers’ inherent commitment to altruistic based values and towards working in a socially responsible manner.

It has been argued in this thesis that this approach in conjunction with other parallel and more locally adopted strategies dedicated towards encouraging a more positive experience of the interactions between the public and NHS managers is also likely to challenge the existing negative public image of NHS managers. Some of these strategies such as the “ABC” and “XYZ”



initiatives<sup>117</sup> were already being implemented within the NHS Trust involved in this study. Furthermore it is also suggested that NHS managers should be given greater opportunity to take personal responsibility towards challenging their negative public image by demonstrating their commitment to the NHS altruistic ethos in a more visible, overt and public manner. A combination of these measures should go some way towards challenging the existing negative public image of NHS managers and to cultivate an improved public perception of NHS managers. This in turn should contribute towards mitigating some of the tensions and challenges experienced in the self and work identities of the NHS managers and play a positive role in sustaining, and possibly enhancing, their overall commitment to the NHS and towards working in a socially responsible manner.

It is likely that an improved public image of NHS managers will also have an impact on those managers who may not have consciously joined the NHS for altruistic motives. In such cases an awareness of their socially responsible role would lead them to re-examine and perhaps enhance their commitment and contribution to the NHS. Needless to say politicians also need to refrain from attempting to escape political accountability by regarding NHS managers as scapegoats for failure of government policy.

On a wider scale the findings of this study has policy implications when generalised to the broader national and international public sectors especially in situations where managers espouse an inherent commitment to altruistic based values which are in line with the socially responsible ethos

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<sup>117</sup> The names of these initiatives have been changed in order to safeguard the anonymity of the NHS Trust and participants involved in this study.

of their organisation but yet may believe that the public view them negatively. Examples of such public sector organisations include those involved in the caring or education based vocations such as the Social Services and the Department of Education. Further research in this field should prove useful.

The next section outlines the contribution to knowledge made by this study.

#### **9.4 Contribution to Knowledge**

As a world renowned, monolithic and politically sensitive complex organisation the UK NHS attracts interest from a broad range of stakeholders. Consequently there already exists a vast amount of literature within the various public and academic domains reporting research undertaken in almost every aspect of the NHS including the NHS managerial culture. However given that the NHS is a highly dynamic organisation the research undertaken and reported is far from exhaustive. In the context of the NHS managerial culture which is the main focus of this study, newer or different avenues of research appear to be emerging just as fast if not faster than existing areas have been explored. These avenues emerge for a variety of reasons, not least because of the interest generated in a wide range of stakeholders by the on-going metamorphosis of the NHS as it is subjected to a never-ending cycle of reforms and their resultant implications for the NHS managerial culture. This is further combined with the quest by scholars and researchers to regard the NHS managerial culture as a useful template for understanding and enhancing managerial performance and effectiveness generally and for developing further ideas and theories in the field.

It is in this context that the author of this thesis has sought to develop a deeper understanding of the NHS managerial culture and more specifically in relation to issues connected to the NHS managers' perceptions of their public image and the impact and implications of this upon the NHS managers' psyche and their overall commitment and contribution to the NHS. The findings of this study provide a contribution to knowledge and offer unique insights into these issues in two particular ways. Firstly, the findings of this study develop an understanding of the extent of the strength of the NHS managers' commitment towards the altruistic based values befitting the NHS ethos. Furthermore, this study confirms the widely reported view that NHS managers believe that the general public view them negatively and do not recognise their commitment towards altruistic based values and towards working in a socially responsible manner. However this study also provides a unique understanding of the implications of this perceived negative public image upon the NHS managers' self and work identities.

These unique insights were developed by exploring the NHS managers' core values and more specifically investigating the tensions in the relationship between their commitment towards working in a socially responsible manner and their perceived poor public image. These findings have been discussed and developed through drawing upon the relatively disparate fields of studies related to Organisation Culture, New Institutional Theory, Identity Theory and Corporate Social Responsibility in an integrated manner so as to allow for a more holistic and deeper understanding of the complexities of the issues related to the NHS managers' self and work identities. The unique nature of these findings contribute towards addressing the current lacunae in existing research and

also have wider implications for managers working in other public sector organisations with a similarly strong socially responsible ethos as outlined earlier in this chapter.

## **9.5 Significance of this Study**

The UK NHS attracts interest from a diverse range of stakeholders within the national and international arenas on account of its sheer size and organisational complexity and it is held internationally as a template for the provision of high quality healthcare free at the point of delivery.

Consequently because of its significance there exists a vast amount of published research within the public and academic domains relating to almost every aspect of the NHS including the NHS managerial culture. It is worth noting that the majority of the studies that have engaged in exploring and developing an understanding of issues connected to the NHS and the NHS managerial culture have been characterised by a predominantly quantitative and positivist approach though more qualitative based studies have become increasingly evident in this field over the last few decades. Such qualitative based studies (like the one reported in this thesis) examining a wide range of issues connected to the NHS and the NHS managerial culture have sought to develop and advance knowledge in this field through developing deeper and richer insights into these issues. By adopting a predominantly qualitative and interpretive approach towards examining some of the main issues related to the NHS managerial culture, this study has contributed to this increasing tide of qualitative based studies examining this domain. More specifically this study has contributed towards developing a deeper understanding of the extent of the strength of

the NHS managers' commitment towards altruistic based values befitting the NHS ethos.

The quest by scholars to understand how managers construct and reconstruct their work and self identities has become increasingly popular within the organisation studies discipline in recent times. In the context of healthcare management, the published studies have tended to be preoccupied mainly with exploring the (re)construction of managerial identity of clinical professionals such as doctors, nurses and other clinical practitioners who have transitioned from a clinical role to a predominantly or exclusively managerial role. The study reported in this thesis has helped to broaden this area of research by exploring the implications of more macro external based factors, such as the impact of the NHS managers' perceived public image, upon their self and work identities. The consequent tensions and challenges arising therefrom is considered to be significant since how managers (re)enact their self and work identity has implications for their work performance, organisational commitment and satisfaction. Additionally through undertaking comparative interviews with healthcare managers working in the private sector, this study has contributed towards developing a wider understanding of the extent to which the key issues central to this study are unique to the NHS managerial culture or if they are equally pertinent to the wider healthcare managerial sector.

On a broader scale the findings of this study has policy implications for the wider national and international public sectors. This is particularly relevant in the context of those areas in the public sector where managers hold altruistic based values in line with the socially responsible ethos of their organisations but yet believe that the public regard them negatively. Examples of such instances include public sector managers working in the

caring or education based fields such as the Social Services and the Department of Education. Further research in this field should prove useful.

## **9.6 Limitations of the Study**

Although this study provides relatively novel insights into issues related to the UK NHS managerial culture it is relatively limited in scope as it involves interviews with a relatively small number of healthcare managers working within an NHS Trust and a private hospital in London. However whilst the validity and reliability of the findings of this study are strengthened when considered in the context of the findings from the two separate studies reported by the author previously in 2005 and 2006, the geographical scale of this study is still relatively small given that for practical reasons it was restricted to interviews with healthcare managers working in London rather than nation-wide.

It is also important to recognise that the findings of this study are based solely on the views and opinions expressed by the healthcare managers during the one to one interviews conducted with them and it cannot be assumed that their espoused views and opinions will remain the same nor that they necessarily reflect and represent their actual enacted day to day actions within their natural work place settings. The repeat interviews undertaken in this study however proved useful in this regard as they allowed the researcher to revisit views and issues that had emerged in the previous interviews conducted with the same managers. Such repeat interviews proved particularly valuable not only in assessing the consistency and conviction of the views and opinions expressed by the NHS managers in previous interviews but also in exploring the extent to

which there may have been any changes in the managers' views from the previous interviews and to explore possible reasons behind such changes.

## **9.7 Avenues for Further Research**

Whilst the findings of this study provide interesting and relatively novel insights into some of the key issues related to the UK NHS managerial culture they do open up new questions and potential avenues of research. It would be useful to continue to further explore the issues related to the challenges and tensions experienced by the NHS managers especially given the present major wave of NHS reforms precipitated by the Health and Social Care Act 2012. As management costs are drastically cut by these reforms there will inevitably be an even greater demand placed on the reduced numbers of managers as they continue to play an instrumental role within the NHS albeit in a changed organisation structure. It would also be useful to extend the scope of this study to include NHS managers working nationwide and those managers working in the international public healthcare sector in order to explore the extent to which the issues identified in this study also apply to them. In future studies it would also be worthwhile considering expanding the data collection methods adopted in this study with a view to including observations of the healthcare managers in their natural workplace settings as they interact with each other, with patients and the public. This would help to examine the extent to which their espoused values are reflected in their actual enacted behaviours so as to develop a deeper and richer understanding of the main issues explored in this study.

In the longer term given the highly political and public profile of the NHS it is inevitable that the NHS will continue to experience on-going changes and reforms of varying scale during its lifetime thereby providing continued scope for further research into examining the implications of these future changes for the NHS managerial culture.

## **9.8 Final Remarks**

Through qualitative based interviews the author has explored in this thesis the NHS managers' core values and more specifically the tensions arising from the relationship between the extent of their commitment towards working in a socially responsible manner and their perceived public image. Comparative primary research interviews with the private healthcare managers involved in this study proved valuable in identifying those key issues explored in this study that were unique to the NHS managerial culture and those that were applicable more widely to the healthcare managerial culture. These insights have led to the development of a useful body of knowledge which has been generated through drawing upon the relatively disparate fields of studies related to Organisation Culture, New Institutional Theory, Identity Theory and Corporate Social Responsibility in an integrated manner so as to allow for a more holistic and deeper understanding of the complexities of the issues related to the NHS managers' self and work identities. As this study comes to an end it is important to recognise that the UK NHS is a highly political and dynamic institution which is once again presently experiencing yet another major set of government led reforms that are likely to have significant implications for the NHS managerial culture. In the longer term the on-going



metamorphosis of the NHS will lead to an evolving organisation with new challenges for its managerial and non-managerial staff. What is certain is that newer or different avenues and scope for research in the short and long term will keep emerging just as fast if not faster than existing areas have been explored.

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## **Appendix A: Schedule of Interview Questions**

### **1. Why did you join to work for the NHS/private hospital?**

- (Purpose of question: to identify managers' personal motives, values and identity - relevant to research objective 1).

### **2. In relation to Question 1 above, if I could turn the clock back to when you made your decision to join the NHS/private hospital, would you still make the same decision today having had the benefit of hindsight? Why?**

- (Purpose of question: to identify the strength of the managers' commitment to the NHS/private hospital – related to research objective 1).

### **3. Do you think there is any difference in relation to being an NHS/private hospital manager rather than being a manager within a private sector/another organisation? Why?**

- (Purpose: to identify occupational/professional values perceived by the managers to be unique to the NHS/private hospital – related to research objectives 1 & 3).

### **4. How do you think the public perceive you as an NHS/private hospital manager? Why?**

- (Purpose: to explore the NHS/private hospital managers' view of their public image – related to research objective 2).

### **5. If I met you for the first time as a stranger at a party and asked you what you do in your job, what would you answer?**

- (Purpose: identify any issues related to their self and work identity – related to research objectives 2 & 3).

### **6. Does the way in which you feel the public perceives NHS /private hospital managers affect your contribution and commitment to the NHS/private hospital and/or how you feel about your job?**

- (Purpose: to identify the implications of the managers' perceived public image for their contribution and commitment – related to research objectives 2 & 3).

### **6b (This question only asked depending on response to 5 above). What do you think could be done to change the public's image of NHS/private hospital managers such that it more realistically reflects reality?**

- (Purpose: identify strength of managers' feelings in relation to their perceived public image – related to research objectives 2, 3 & 4).

**7. This question asked depending on the response to question 6 & 6b.**

Precise wording of question will depend upon response to questions 6 & 6b - seek to explore the managers' views about their organisation's CSR strategy and whether having an explicit statement in their organisation's CSR strategy regarding the recognition of their commitment to working in a socially responsible manner would help to improve their public image.

- (Purpose: identify managers' views about their organisation's CSR strategies and any need for possible changes to this strategy – related to research objectives 2, 3 & 4).

**8. This question only applies to the re-interviewees.**

Precise wording of question will depend upon key issues addressed in previous interviews with the aim to explore if there have been any changes to the managers' views expressed in previous interviews in relation to these issues.

- (Purpose: to identify any changes to key views/issues identified in previous interviews – related to research objectives 1, 2, 3).

**9. Where do you see yourself career-wise in five years' time? Why?**

- (Purpose: to identify future plans/commitment to the NHS/private hospital – related to research objectives 1 & 3).

## Appendix B: Research Questionnaire

**Please answer all questions, entering information/ticking the boxes as appropriate.**

1. Your age group:			
16 - 20	<input type="checkbox"/>	41 - 50	<input type="checkbox"/>
21 - 30	<input type="checkbox"/>	51 - 60	<input type="checkbox"/>
31 - 40	<input type="checkbox"/>	61 +	<input type="checkbox"/>

2. Total no. of years you have worked in the NHS/Private Hospital:
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3 Your Present Job Title:
Your Seniority: (Senior/Middle/Junior Management)

4. Number of years you have worked in the NHS Trust/Private Hospital:
---

5. Do you come from a background of:	
a) Management/administration	<input type="checkbox"/>
b) Nursing	<input type="checkbox"/>
c) Other medical (please specify)	<input type="checkbox"/>
d) Other (please specify).	<input type="checkbox"/>

6. Is your current job:	
Clinical only	<input type="checkbox"/>
Non-clinical only	<input type="checkbox"/>
Combination	<input type="checkbox"/>
If combination specify % breakdown between clinical & non-clinical time	
<input style="width: 80%;" type="text"/>	

7. Do you have any direct responsibility for managing staff?	
Yes	<input type="checkbox"/>
No	<input style="width: 40%;" type="text"/>
If Yes how many staff do you manage (please specify if they are clinical/non-clinical)	
<input style="width: 90%;" type="text"/>	

## Appendix C: Examples of Coding used for Interview Transcripts

Interviewer: OK, thank you again for participating in this study. What I'd thought I'd like to start with is go back to something that we discussed briefly at our last interview which is you've been in the NHS now for fourteen years, could you tell me why you decided to join the NHS?

Interviewee: *OK. Why the NHS was I think quite clear. I wanted to work in either the public or voluntary sector and that was a combination of wanting to do a job that had some sort of value in society so obviously there is a judgement there that public sector, voluntary sector would have value. And I think wanting to make a difference to key things and I guess there were things about public sector values at that time that tied in with my values at the time...*

CORE  
VALUES

mot

ALT

Nc9 - NHS Senior Manager, Non-Clinical Background.

NHS  
snr  
nc

### Key to codes:

“mot”: motivation; “ALT”: Altruistic motives; “Core Values”: works in NHS; “snr”: senior grade manager; “nc”: non-clinical background.

Interviewer: Your role is significantly, about 80% management oriented. How do you think the public in your view perceive NHS managers and why?

Interviewee: *Oh I think the media play a large part in it, you know the grey suits brigade and the bureaucracy and the fact that you know, the number of, you know those newspaper reports, the number of managers has trebled in the last five years, etcetera, etcetera you know.*

C2 -NHS Senior Manager, Clinical Background.

### Key to codes:

“pub-per”: public perception; “-ve”: negative; “Public Image”; “NHS”: works in NHS; “snr”: senior grade manager; “cl”: clinical background.

Interviewer: Talking about the public perception, again something we did discuss last time was what your view was on how you think the public see managers within the NHS. Could you just briefly tell me what you think about that now?



Interviewee: *I still think it's incredibly negative. I don't think it's helped by the press at all...*

Nc9 - NHS Senior Manager, Non-Clinical Background.

**Key to codes:**

“pub-per”: public perception; “-ve”: negative; “Public Image”; “NHS”: works in NHS; “snr”: senior grade manager; “nc”: non-clinical background.

---

Interviewer: If I met you for the first time as a stranger at a party and asked you what do you do for a living, how would you introduce yourself?

Interviewee: *I think if I met you at a party and you said what do I do, I'd say I'm a midwife so I think that's different, you don't say I'm a manager in the NHS...*

C2 - NHS Senior Manager, Clinical Background

**Key to codes:**

“mgt-ttle”: management title; “CONC”: concealed; “IDENTITY”; “NHS”: works in NHS; “snr”: senior grade manager; “cl”: clinical background.

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Interviewer: So do you think there is a difference in the way the public perceive NHS managers and managers like yourself working in a private healthcare environment such as (name of private hospital)?

Interviewee: *I think we're seen as more professional, yeah, and more sort of kind of quality orientated than NHS managers, I think, I mean the public view us as more professionally driven...*

CB - Private Healthcare Senior Manager, Clinical Background

**Key to codes:**

“pub-per”: public perception; “+ve”: positive; “Public Image”; “PH”: works in private hospital; “snr”: senior grade manager; “cl”: clinical background.

---

Interviewer: Is there any difference do you think in the way the public view managers like yourself working in private healthcare?

Interviewer: *Yeah, I would say that they would probably think that we're a bit sharper than the NHS management...*

NcI - Private Healthcare Middle Manager, Non-clinical Background

**Key to codes:**

“pub-per”: public perception; “+ve”: positive; “Public Image”; “PH”: works in private hospital; “mid”: middle grade manager; “nc”: non-clinical background.

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Interviewer: Do you think there is a similar public perception of private healthcare managers?

Interviewee: *I don't, there doesn't seem to be that much in the press about private healthcare, it's sort of kept out of (ear) shot, you don't see much about private hospital managers in the papers.*

NcH - Private Healthcare Middle Manager, Non-clinical background

**Key to codes:**

“pub-per”: public perception; “indiff”: indifferent; “Public Image”; “PH”: works in private hospital; “mid”: middle grade manager; “nc”: non-clinical background.

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Interviewer: If I met you for the first time as a stranger at a party and asked you what do you do for a job, how would you introduce yourself?

Interviewee: *I would say to you that I'm a (gives specialist clinical title).*

Interviewer: Why is that since it doesn't reflect the day to day reality of your work as you are performing in an exclusively managerial position with no clinical duties?

Interviewee: *It doesn't you're right...I want to show I understand the clinical side which is why management takes a second seat.*

CA - Private Healthcare Middle Manager, Clinical background

**Key to codes:**

“mgt-tle”: management title; “CONC”: concealed; “IDENTITY”; “PH”: works in private hospital; “mid”: middle grade manager; “cl”: clinical background.

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## Appendix D: Demographic & Professional Profile of Interviewees

	NHS Trust (Guy's)	Private Hospital	Total
<b>Number of Interviews</b>	10	10	<b>20</b>
<b>Male</b>	4	5	<b>9</b>
<b>Female</b>	6	5	<b>11</b>
<b>Repeat Interviews</b>	5 (3 second time interviews & 2 third time interviews)	0	<b>5</b>
<b>Age Range (years)</b>			
21-30	0	1	<b>1</b>
31-40	0	5	<b>5</b>
41-50	7	4	<b>11</b>
51-60	3	0	<b>3</b>
<b>Seniority, Background &amp; Length of Service</b>			
Senior Manager	10	6	<b>16</b>
Middle Manager	0	4	<b>4</b>
Managers with a Clinical Background	4	5	<b>9</b>
Managers with a Non-Clinical Background	6	5	<b>11</b>
Average Number of Years Spent Working in the Healthcare Profession	26.7	14	<b>N/A</b>
Average Number of Years Spent Working in the Current Institution	13.8	7.15	<b>N/A</b>